Convergent Mental Health and Wellness, LLC
213 Old Padonia Rd, Cockeysville, MD 21030
443-840-8994

Consent For Treatment

WHAT IS THERAPY:

Therapy offers a unique space where people experiencing life challenges can share their difficulties, and externally process their thoughts and feelings. This happens individually with a licensed therapy clinician or with other clients in group therapy. In the context of a safe therapeutic space, clients can learn skills and consider new perspectives to navigate personal and relational challenges.

WHAT TO EXPECT IN THERAPY:

As a client in therapy, you will be encouraged to process your personal experiences while your therapist and / or group members provide active listening, validation, feedback, and supportive reaction towards your stated issues. This process helps clients reflect on their situation from new perspectives and promotes personal growth and insight development. When appropriate, your therapist will offer psychoeducation and skills training to support you in understanding and navigating your stated concerns.

Your therapist will work to maintain a safe environment that:

- is conducive for sharing

- promotes a sense of acceptance

- encourages growth and trust

- communicates value and respect

Patients must give voluntary consent for treatment. Your signature below will demonstrate consent for receiving treatment from Convergent Mental Health and Wellness, LLC.

I, _____ consent mental health treatment and other holistic wellness services as performed by Convergent Mental Health and Wellness and its employees. This treatment may include but is not limited to: assessment, screening, consultation and recommendations, psychotherapy, yoga, and holistic services. I understand that my treatment may involve certain risks and benefits and I understand these risks and benefits. I also understand the risks and benefits of declining treatment. I am aware I have the right to end treatment at any time or request information about alternative treatment options, should they exist.

I have read the above information and I authorize Convergent Mental Health and Wellness to provide me with their services.

_____ _____

Client / Guardian Signature **Date (MM/DD/YYYY)**