**Consent to Treatment**

I understand that the treatment offered by Bolden Therapy & Wellness, LLC is of voluntary nature. I understand that with certain limits, information revealed will be kept strictly confidential. However, I also understand if I reveal information, which indicates that I may be a threat to myself or others, that my therapist is required by law to reveal this information to other persons or agencies for my safety and the safety of others. I understand that my treatment may be discussed in supervision with other clinicians for the purpose of providing you the best treatment, including shared images, recordings, or drawings in Play Therapy and/or Sandtray Therapy sessions.

I understand that Bolden Therapy & Wellness, LLC does bill insurance companies. I understand that it is my responsibility to provide accurate and current information for billing services including insurance and form of payment. I understand that payment is due at the time of services, and I am financially responsible for payment of fees as well as missed sessions. Please give at least 24-hr notice if an appointment needs to be cancelled. If your child is sick and you have an emergency, please call the office as soon as possible to reschedule another time that week. I understand the late cancellation and no-show policy and that missed sessions are subject to a $65 fee.

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Client Signature Date

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Guardian Signature Date

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Guardian Signature Date

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Therapist’s Signature Date