



Counseling Colorado, PLLC
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Individual Consent Form

I _____ being 18-years of age or older do hereby consent to counseling. I realize that all information shared in therapy that is not required by law to be revealed to the proper agency is private and confidential.

For the Client/Guardian: The right to confidentiality is maintained with two exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others, including your child.

For the Child: The right to confidentiality is maintained with three exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others.
3. The professional has reason to believe that someone or something is harming you including your parents.

At any time I or my therapist may terminate therapy. I also permit my therapist to consult with doctors, psychiatrist, psychotherapists or other professionals as the need arises.

By signing below, I agree to be seen for counseling.

Client Signature

Date

Guarding Signature

Date

Counselor Signature

Date