Lisa F. Ligammari, LCSW
315 Rt-34, Suite 106, Colts Neck, NJ 07722
80 Bridge Plaza Dr., Manalapan, NJ 07726
732-648-6423 | lisaligammaricounseling.com

Informed Consent for Treatment

You can type directly into the shaded fields on a computer, or print this form and fill it in by hand. Please sign and date where indicated.

Patient Name: _____ **Date of Birth:** _____

I request that I or my child (named above) be accepted for mental health treatment by Lisa F. Ligammari, LCSW, LLC Counseling Services & Associates. I agree to the following:

1) I give my consent to receive counseling and diagnostic treatment services from Lisa F. Ligammari, LCSW, LLC Counseling Services & Associates.
2) I have been given information regarding my rights & responsibilities as a patient.
3) I have been given information regarding PHI & the limits of confidentiality of my records.
4) I have been given the information regarding the cost of services. I understand that I may be responsible for deductibles, copayments, co-insurance or self-pay that I will pay each time I receive treatment.
5) I understand that I may address any concerns or grievances with my therapist at any time. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
6) I am freely choosing to enter into treatment and I understand that I may discontinue treatment at any time.
7) I have been given information about the advantages and possible disadvantages of the treatment, any recommended treatment or alternatives as well.

Signature of Patient or Guardian: _____ **Date:** _____