



**Dr. Alyx MacTernan, Ed.D., LPC, NBCC**  
**Informed Consent Agreement**

**Agreement and Consent for Counseling and Treatment**

I have read (or have had read to me) the information in the Informed Consent Agreement. I have been given the opportunity to ask questions about this agreement. I understand my rights to privacy, the exceptions to my rights to privacy and that there are risks associated with treatment. I agree to abide by the payment policy and accept full responsibility for any and all fees incurred for my counseling or if appropriate, counseling with my child(ren).

CLIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to assist in my treatment.

Client(s) or Legal Guardians:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Agreement and Consent for Internet Communications**

\_\_\_\_\_  
Email Address

By providing an email address, I am acknowledging that Dr. Alyx MacTernan or other professional representing Elemental Mental Health can communicate with me via email. Internet communication can pose some security risks and I understand that email and text communication will be limited to administrative concerns such as appointments and payment questions. This consent may be revoked by me at any time except to the extent that action has already been taken as a result of my providing this email address.