



Informed Consent Form for Mental Health Services

Pennsylvania – Client Agreement and Disclosure Statement

This document is designed to provide you with important information regarding your participation in mental health services. Please read this form carefully and ask your mental health provider if you have any questions or concerns before signing. Your signature on this form indicates that you understand the information provided and agree to participate in mental health services voluntarily.

1. Introduction and Purpose

Mental health services are intended to improve your psychological well-being and help you address concerns related to mental health, behavior, relationships, and emotional functioning. These services may include assessment, diagnosis, counseling, psychotherapy, psychoeducation, and referral to other appropriate providers.

2. Provider Information

- Name of Provider: Cristine Cappo, M.A LPC, LBS, NCC
- Practice/Organization: TherAlliance Counseling Services
- Address: 105 W. 3rd St. Media, PA 19082
- Phone: 856-886-8402
- Email: theralliance.pa@gmail.com
- Professional License/Certification: PC014380
- National Provider Identification : 1336721732



3. Description of Services

You will participate in mental health services, which may include:

- Individual, couples, family, or group therapy
- Mental health assessment and evaluation
- Treatment planning and goal setting
- Crisis intervention when necessary
- Referral to community resources as appropriate

The specific nature and goals of your treatment will be discussed with you and documented in your treatment plan.

4. Risks and Benefits

Psychotherapy and other mental health services can have benefits and risks. Potential benefits include improved mood, healthier relationships, and better coping strategies. However, you may experience uncomfortable emotions such as sadness, guilt, anger, frustration, or anxiety as part of the therapy process. There are no guarantees about what you will experience or the outcome of treatment.

5. Confidentiality and Limits

Your privacy is protected by Pennsylvania and federal law. Information you share with your provider is confidential and will not be disclosed without your written permission except in the following circumstances:

- If there is reason to believe you may be a danger to yourself or others
- Suspected child abuse, elder abuse, or abuse of a vulnerable adult (as mandated by Pennsylvania law)
- Court orders or legal requirements
- If you provide written consent to release information



- To coordinate and facilitate your treatment with other healthcare providers (with your consent)
- For billing, payment, and healthcare operations as allowed by law

You may ask for more details about confidentiality at any time.

6. Privacy Practices and HIPAA

Your provider adheres to the Health Insurance Portability and Accountability Act (HIPAA) to protect your health information. You will receive a separate Notice of Privacy Practices explaining how your health information may be used and disclosed.

7. Voluntary Participation and Right to Withdraw

Participation in mental health services is voluntary. You have the right to refuse any recommended services or withdraw from treatment at any time without penalty. If you choose to withdraw, your provider will discuss alternative options, if appropriate.

8. Treatment Planning and Collaboration

You are encouraged to actively participate in the development of your treatment plan and to discuss your goals, concerns, and progress with your provider. You may request information regarding your diagnosis, treatment methods, and expected course of therapy.

9. Length and Frequency of Treatment

The frequency and duration of therapy sessions will be determined collaboratively based on your needs and preferences. Sessions are typically scheduled for 53-55 minutes and occur weekly, bi-weekly, or as otherwise determined. You may terminate therapy at any time.



10. Emergencies and Crisis Procedures

Your provider may not be available outside regular office hours. In the event of a mental health emergency, please use the following resources:

- Call 911, 988, or go to your nearest emergency room for immediate assistance
- Contact the National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- Contact your local County Crisis Intervention Service: _____

Providers will explain procedures for after-hours or emergency contact during your first session.

11. Fees, Billing, and Insurance

- Session Fee: \$_____ per session
- Payment due at the time of service unless other arrangements have been made
- Accepted forms of payment: _____
- Insurance Information (if applicable): _____
- Cancellation Policy: Please provide at least 24 hours' notice to avoid a cancellation fee

You are encouraged to confirm your insurance coverage and benefits before beginning services.

12. Telehealth Services

If you agree to receive services via telehealth (phone or video conferencing), you will receive an additional Telehealth Informed Consent Form. Telehealth is subject to the same standards of confidentiality and privacy as in-person services, though there are some special considerations and limitations that your provider will explain.



13. Client Responsibilities

As a client, you agree to:

- Attend scheduled appointments on time
- Communicate openly and honestly with your provider
- Participate actively in your treatment
- Inform your provider about any changes in your situation, medications, or contact information
- Abide by the policies and procedures of your provider's practice

14. Consent for Treatment of Minors

If the client is under 18 years of age, consent must be provided by a parent or legal guardian unless otherwise permitted by Pennsylvania law.

- Parent/Guardian Name: _____
- Relationship to Client: _____
- Signature: _____
- Date: _____

15. Complaints and Grievances

If you have concerns about your treatment, you are encouraged to discuss them with your provider. If you wish to file a formal complaint, you may contact the Pennsylvania Department of State, Bureau of Professional and Occupational Affairs:

- Phone: (717) 787-8503
- Website: www.dos.pa.gov



16. Acknowledgment and Consent

By signing below, you acknowledge that you have reviewed and understand the information contained in this Informed Consent Form. You have had an opportunity to ask questions and agree to participate in mental health services voluntarily.

- Client Name: _____
- Signature: _____
- Date: _____
- Provider Name: Cristine Cappo, M.A, LPC, LBS, NCC
- Signature: _____
- Date: _____

Please retain a copy of this form for your records.