CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned, agree and consent to participate in the mental health services through telephone/ digital video applications offered and provided by Phoenix Associates, Inc., a mental health provider or psychologist, as defined in Indiana law.

I understand that I am consenting and agreeing only to those mental health services that the above-named provider is qualified to provide within:

a) The scope of the provider's license, certification, and training; or
b) The scope of license, certification, and training of those mental health providers directly supervising services received by the patient.

Signature of Client/Parent/Legal Guardian-
_____

Relationship (if other than client)-
_____

Witness-
_____**Date**_____