ROOTED WINGS, LLC
Stacey L. Jackson, LPC

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Consent for Psychotherapy

I acknowledge that I have received and read the ***Stacey L. Jackson, LPC Professional Disclosure Statement and Practice Policies, Informed Consent for Treatment*** and the ***HIPAA Notice of Privacy Practices, including Client's Rights.*** I further acknowledge that I seek and consent to treatment with Stacey L. Jackson. My signature below confirms that I understand and accept all the information contained in the ***Stacey L. Jackson, LPC Professional Disclosure Statement and Practice Policies, Informed Consent for Treatment and the HIPAA Notice of Privacy Practices, including Client's Rights.***

Client, if over 16

Client/Guardian Full Name	Client/Guardian Signature	Date

If more than one individual (e.g., spouse or family member) is seeking therapy, please have each of the others sign below. Signatures below confirms that each understands and accepts all the information contained in the ***Stacey L. Jackson, LPC Professional Disclosure Statement and Practice Policies, Informed Consent for Treatment,*** and the ***HIPAA Notice of Privacy Practices, including Client's Rights***, and that each seeks and consents to treatment. Additional copies of the ***Stacey L. Jackson, LPC Professional Disclosure Statement and Practice Policies, Informed Consent for Treatment, and the HIPAA Notice of Privacy Practices, including Client's Rights*** upon request.

Client #2 Full Name	Client #2 Signature	Date
Client #3 Full Name	Client #3 Signature	Date
Client #4 Full Name	Client #4 Signature	Date
Client #5 Full Name	Client #5 Signature	Date

Client #6 Full Name	Client #6 Signature	Date