

TRADEPORT COUNSELING AND MEDIATION ASSOCIATES

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**TCMA STAFF**

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**CONSENT FOR TREATMENT FORM**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Tradeport Counseling and Mediation Associates, PLLC to provide counseling for myself and/or the following minor(s), of whom I am the parent or legally constituted guardian.

**NAMES OF MINOR(S):**

Child Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Records that need to be kept in your confidential file will be as follows, as according to HIPPA:

1. The presenting problem(s), purpose or diagnosis
2. The fee arraignment
3. The date and services provided
4. A copy of all tests and evaluative reports prepared
5. Notation and results of formal consults including information obtained from other persons or agencies through a release of information
6. Consent for Treatment
7. Release of Information Forms

Date:\_\_\_\_/\_\_\_\_/\_\_\_\_ Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_/\_\_\_\_/\_\_\_\_ Clinician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_