



**Jarod T. Giger, LCSW**  
*Therapy, Consultation & Supervision for Licensure*

121 North Brentwood Boulevard  
St. Louis, MO 63105  
website: [www.dbtstl.com](http://www.dbtstl.com)  
314-494-8832 office  
[jarodgigerllc@hotmail.com](mailto:jarodgigerllc@hotmail.com)

## CONSENT FOR TREATMENT

I have chosen to receive services through **JARODGIGER, LLC**. My participation is voluntary and I am aware that I may discontinue receiving services at my discretion.

I understand that all information I disclose to my therapist is held in the strictest of confidentiality and may not be released without my written consent. There are some exceptions to this which are allowed or mandated by state and federal law. Some exceptions to confidentiality include, but are not limited to situations where there is: (1) A danger to myself (i.e., client) or another person; (2) Actual or suspected abuse or neglect of children/minors/elderly; (3) Presentation of a valid court order; and, (4) Appropriate discussion of case specifics with other professions for consultation or supervision.

My therapist may disclose any and all records pertaining to my treatment to my insurance company and/or my primary care physician (PCP) as necessary for coordination of treatment, submission and validation of claims, or case management. I may revoke this consent in writing at any time.

I have been informed of the costs services and the risks v. benefits of services. While **JARODGIGER, LLC** will submit my claim to my insurance company, I understand that I am solely responsible for the costs of services should my insurance company not cover services. I have been encouraged to contact my insurance company to determine the scope of mental health services covered by my policy.

I understand that I am solely responsible for the full service fee if I should fail to give at least 24-hour notice to cancel an appointment.

I understand that some information discussed in the course of psychotherapy may be distressing to me, but may be therapeutically necessary to help me resolve my concerns. I understand that alternatives to psychotherapy include treatments v. no treatment.

I understand that in the case of an emergency I am to go immediately to my nearest Emergency Room and/or contact "911" by phone and /or contact Behavioral Health Response at 1-800-811-4760 by phone. Furthermore, I understand that I am to regularly follow up with my Primary Care Physician (PCP) or physician of choice or other appropriate qualified health care provider for all medical questions or concerns and all medication questions or concerns.

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**Client/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

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**Signature of Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

Jarod T. Giger, LCSW, Manager/Member

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**Print Name of Client** \_\_\_\_\_ **DOB** \_\_\_\_\_