Third Space Wellness, LLC

CONSENT TO SERVICES

I, _____, understand that TSW Services (as defined below) are provided by Third Space Wellness, LLC ("TSW") staff and/or affiliated practitioners ("Clinicians"). I understand that this consent covers the Clinician who initially treats me, and any other Clinicians associated with TSW who may provide my treatment in the future.

Welcome to TSW; we are a wellness center offering a multitude of services including acupuncture, massage, nutrition, psychotherapy, yoga and more. We're happy to assist you on your wellness journey and invite you to participate in any of the center's offerings which interest you.

The purpose of this form is to establish consent and ground rules for Psychotherapy services at Third Space Wellness.

I hereby give my consent to receive the following TSW Services:

Psychotherapy

Psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. I understand that there are no guarantees about what will happen as a result of my treatment. I understand that psychotherapy requires a very active effort on my part. In order to be most successful, I understand that I will have to work on things we discuss outside of sessions.

Potential Risks: I understand that, psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life.

Confidentiality:

In general, the privacy of all communications between a patient and your Clinician is protected by law, and TSW can only release information about our work to others with your written permission. But there are a few exceptions:

1. In most legal proceedings, you have the right to prevent TSW from providing any information about your treatment. In some legal proceedings, a judge may order your Clinician's testimony if he/she determines that the issues demand it, and TSW must comply with that court order. For this reason notes are kept in a general format to not reveal specifics of client information.
2. In the all states including Maryland, the District of Columbia, and Virginia, Clinicians are legally obligated to report suspicions of child or elder abuse to the appropriate state agency.
3. Confidentiality may be breached if there is a believed intent to harm yourself or another person.

Medical Treatment: Our Clinicians are not a substitute for a medical doctor and will not suggest that I discontinue medical treatment. I understand that if I am currently under a physician's care, I should continue as long as my physician and I deem it necessary. It is my responsibility to consult with my physician before altering any prescribed medications or treatments. I understand also that if there is an emergency, or a worsening of my health condition, or if a new condition arises, that I should consult a licensed physician.

Voluntary: I hereby request and consent to receive TSW Psychotherapy services. I have not been guaranteed any specific outcomes concerning the uses and effects of any TSW Service. I understand that I am free to discontinue any TSW Service at any time. I voluntarily assume all risks inherent in the nature of each of the TSW Services. I waive all claims, costs, liabilities, expenses and judgments against TSW and release TSW and its members, officers, agents, representatives, and employees from all claims, costs, liabilities, expenses, and judgments arising out of the TSW Service.

Additional Information:

Fees: Individual therapy sessions are 50 minutes in duration. I have read and discussed the schedule of fees with my Clinician and agree to pay the agreed rate at the time of service.

Health Insurance Benefits: I may request a receipt of payment to submit for reimbursement with my health insurance provider. In order for benefits to be available I understand that my Clinician must make a psychiatric diagnosis about my condition, which may or may not be possible.

Cancellation Policy: I have read and reviewed the cancellation policy on the Acknowledgement of Fees form with my Clinician and agree to this cancellation policy.

Office Hours: Psychotherapy sessions are by appointment only. I am aware that I may reach my Clinician outside of our schedule time by calling the TSW number or via email at rosenny@thirdspacewellness.com. I am aware that the general number is not a confidential line. I am aware that I can expect my therapist to return my message within 24 hours or the next business day.

Emergencies: In the event of a psychiatric emergency (emergencies in this case refer to suicidal, violent or homicidal thoughts or intent) I agree to go to the nearest emergency room or call 911.

Therapist leave: My Clinician will inform me in advance of scheduled absences or changes in his/her schedule. Should there be an extended absence, my Clinician and I will discuss a plan for care during that time.

I understand that the policies and procedures of TSW are available at thirdspacewellness.com, and I can visit the website to review additional information about the following: general office hours, office closings, and general information about the center.

By voluntarily signing below, I confirm that I have read, or have had read to me, and understand the above Consent to Services, have been told about and understand the risks of the TSW Service, and have had an opportunity to ask questions and have received satisfactory explanations. I understand that I can request more information at any time if desired. I understand that I have the right to refuse or discontinue any service any time and that this refusal may affect the expected results I am seeking. I intend this consent form to cover the entire course of treatment for my present condition and/or my current wellness goals, as well as for any future condition(s) and/or goals for which I seek these services.

Third Space Wellness, LLC
8001 Kennett Street, Suite B, Silver Spring, MD 20910
301.328.5326 | info@thirdspacewellness.com

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PLEASE PRINT:

Print Patient Name	Patient Birth Date
Street Address	City, State and Zip Code
Email Address	Preferred Phone Number
Emergency Contact Name	Emergency Contact Phone Number
Signature (or parent or guardian signature if client is a minor)	Today's Date

☐ YES, I agree to abide by the Third Space Wellness Community Code of Conduct. (Available at the front desk and online at thirdspacewellness.com.)

☐ Please exclude me from your mailing list*. (We do not sell our mailing list.)

**Note: We may still use your email address to send you health-related emails pertinent to treatment or updates from your Clinician.*

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