**Counseling Informed Consent**

Initial after each paragraph, sign and date at the bottom.

**Confidentiality:** Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission except where disclosure is required by law.

**Consent to Treatment:** I am voluntarily seeking psychotherapeutic services. I understand that I am responsible for my part in the therapy process, which includes providing honest information to my therapist, and follow therapeutic instruction and completing homework and reading exercises. I realize that refusal to follow recommendations, being dishonest or withholding of information related to my problem could jeopardize my well-being. I understand that there are uncontrollable factors and that no guarantee is expressed or implied. If I feel the urge to hurt myself or someone else, I agree to contact my therapist, dial 911, call my physician or go to a hospital.

**When Disclosure Is Required By Law:** Disclosure is required or may be required by law when there is a reasonable suspicious of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client’s family members communicate to me that you present a danger to others. Disclosure may also be required by the courts. I will not release records to any outside party unless I am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

**Emergency:** If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the biographical sheet.

**Health Insurance & Confidentiality of Records:** Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier.

**Records and Your Right to Review Them:** The law requires that I keep treatment records for at least six (6) years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults involved in the treatment.

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_