Gilbert Counselors, LLC

Professional Counseling Services

1425 W. Elliot Rd, Suite 201 * Gilbert, AZ 85233 *
gilbertcounselors.com

Informed Consent for Treatment

- ❑ I am completing this consent for treatment for myself.
  Name _____
- ❑ I am completing this consent for treatment for a minor child.
  Name _____
  Child's Name _____

Welcome! I look forward to working with you. I know that starting counseling is a major decision and you may have many questions. The purpose of this document is to inform you about what you can expect from counseling and to give you the opportunity to give consent to proceed with the counseling process. We will discuss this during our first session.

Please mark the corresponding box for each paragraph that you read and understand below:

- ❑ I choose to participate in therapy services with _____ and/or
- ❑ I give permission to _____ to provide therapy services to my minor child.

❑ I understand that participating in these services is voluntary and collaborative, and that I may end services for myself or my child at any time. I agree to verbally advise _____ when I decide to terminate services. I understand that, unless otherwise contracted, no contact for 30 days will result in file closure; my file may be reopened upon agreement by both parties.

❑ I understand that I will be participating in individual, couples, or family therapy services to address issues and concerns that I share with my therapist. I understand that the focus of these services is on helping me reach my individual/couple/family goals. I understand that there are no guarantees that these services will make me or my partner/family members feel better or resolve my problems, issues, or concerns. Further, although I understand that counseling often results in positive outcomes, I also understand that the counseling process can open up levels of awareness that are painful (e.g. I could feel upset, anxious, angry, and/or uncomfortable).

❑ I understand that my client record will be kept confidential, and that confidentiality includes all aspects of the topics discussed within the therapeutic setting. I also understand that, by law, there are limitations to confidentiality in cases when one or more of the following occur: **Intent to commit suicide; Intent to commit homicide; Any other act or intention to act in a way that may be a danger to self or others; Information regarding child or elder abuse that mental health providers are mandated by law to report; A court subpoena for records; Information regarding unprofessional conduct by another behavioral health professional. In addition, I understand that my therapist is justified in informing an identifiable third party of risk of contagious/fatal disease.**

❑ I understand that my therapist may consult or seek supervision from a colleague when it is required or deemed necessary, in order to ensure quality care. I understand that my identity will be protected.

❑ I understand that E-Mail, fax, and cell phone communications are not guaranteed confidential methods of communication. Therefore, I understand that if I choose to contact my therapist via one of these methods, that it is by choice, and therefore relinquish my rights of confidentiality.

❑ I understand that I have a right to request a copy of my record in writing. I understand that I also have the right to sign a written authorization that will allow my therapist to give and/or receive information verbally and in writing with individuals or entities that I designate.

❑ I understand that I have the right to participate in treatment decisions, including the development of my treatment plan. My therapist will work with me to determine the recommended services based on my situation; however I have the right to refuse treatment and to withdraw my informed consent for treatment by providing a written request. I understand that if I submit this request, _____will no longer be able to provide me with services.

❑ I understand that my therapist and / or Gilbert Counselors, LLC has the right to terminate services with me, whether for therapeutic or personal reasons. I understand that should this occur, I will be provided with information on how to obtain alternative therapy services (i.e. referral to another therapist or treatment provider).

❑ I understand that the therapy relationship is exclusively therapeutic (e.g. It is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions). I understand that the purpose of these boundaries is to ensure that you (therapist) and I (client) are clear in our roles for treatment and that my confidentiality is maintained.

I/We have read and understand the above information and have discussed all aspects of informed consent with my/our therapist.
I/We hereby consent to receive counseling services from Gilbert Counselors, LLC

_____ _____
Signature Date

_____ _____
(Signature of Therapist) Date

Minor or Individual With A Guardian

I/We, the parent(s) or guardian(s) of _____ have read and understand the above information and have discussed all aspects of informed consent with _____. I/We consent that _____may be treated as a client by _____.

_____ _____

Signature of parent/guardian Date

_____ _____

(Signature of Therapist) Date