



Spokane Holistic  
Healing

## Spokane Holistic Healing Client Handout Client Consent and Confidentiality Form

**Client Name:** \_\_\_\_\_

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

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

### Introduction

Welcome to our counseling services. This form provides important information about the counseling process, confidentiality, and your rights as a client. Please read this document carefully and discuss any concerns with your counselor before signing.

### Consent for Treatment

I, \_\_\_\_\_ (client's name), voluntarily consent to receive mental health counseling services. I understand that counseling may involve discussing personal challenges, emotions, and experiences, and that outcomes may vary. I acknowledge that I may withdraw from counseling at any time but will notify my counselor if I choose to do so.

### Confidentiality

Your privacy is important to us. Information shared in counseling sessions is confidential and will not be disclosed without your written permission, except in the following situations:

1. If there is a risk of harm to yourself or others.
2. If there is suspected abuse or neglect of a child, elderly person, or dependent adult.
3. If disclosure is required by law, such as a court order or subpoena.
4. If you provide written consent to release specific information to a third party.
5. If counseling services are provided as part of a legal case or employee assistance program, where limited disclosure may be required.

### Limits to Confidentiality

While we make every effort to maintain confidentiality, there are legal and ethical situations where disclosure is necessary. If any of these circumstances arise, we will discuss them with you whenever possible before taking action.



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## **Electronic Communication**

I understand that electronic communication (e.g., email, text, telehealth sessions) carries some risk regarding confidentiality. While precautions are taken to protect information, absolute security cannot be guaranteed.

## **Fees and Cancellation Policy**

- Session fees: \$\_\_\_\_\_ per session. Payment is due at the time of service unless otherwise arranged.
- Cancellations must be made at least 24 hours in advance. Missed appointments or late cancellations may result in a fee.

## **Client Rights**

As a client, you have the right to:

1. Receive services in a safe and respectful environment.
2. Ask questions about your treatment and counseling methods.
3. Decline or withdraw from counseling at any time.
4. Request access to your counseling records (with some legal restrictions).
5. Express concerns or complaints regarding services.

## **Consent and Acknowledgment**

By signing below, I acknowledge that I have read, understood, and agree to the terms outlined in this document. I have had the opportunity to ask questions and understand the limits of confidentiality.

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Counselor Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_