



DESCRIPTION OF THERAPY SERVICES:

I have voluntarily sought counseling on my own initiative. I understand that I may accept or reject any of the counsel that I may receive from Kim Mahn, Licensed Martial and Family Therapist (LMFT License #047) in the state of Oklahoma.

I understand that counseling involves discussing, in detail, my concerns, which may include giving background information, and communicating about areas of my life that may cause me emotional pain. The purpose of my disclosures is for me to develop new and more effective methods of coping with problem areas in my (and/or my child's) life. I understand that I may withdraw from counseling services at any time if I so desire.

In receiving counseling from Olive Branch Clinic, I acknowledge and agree this service is extended to me with the understanding it will not serve, **presently, or in the future**, to fulfill any counseling requirement **for any civil or criminal related court proceeding or litigation.**

Release of Liability:

I, for myself and my heirs, personal representatives, assigns and agents, expressly release, forever discharge, and hold harmless Kim Mahn, LMFT, from all liability, loss damage, claims or actions, for injuries or counseling which I have received or will receive, even if caused by negligence of Kim Mahn LMFT.

Confidentiality:

All confidential records are securely maintained and only accessible by Olive Branch Clinic Staff. All services received and all information obtained from you are kept confidential and cannot be released without your permission, by you (or your legal guardian's) signed written release of confidential information. However, there are special situations under which confidential information could be revealed. These are:

1. Whenever a "Duty to Warn" or "Duty to Protect" ethic requires your counselor to break confidentiality, confidential information may be disclosed. Your counselor is required by state law to report the following: risk of suicide or homicide, suspected or confirmed reports of child/elderly or incapacitated adult abuse or neglect.
2. Under very limited circumstances, the court may issue an order compelling the disclosure of your records and may order a counselor to give testimony during a court hearing. In a lawsuit, a party may also subpoena records, but generally in the case of subpoena, HIPAA would require that you sign an authorization to release these records or that you were informed of the potential disclosure and had an opportunity to object.
3. I understand and agree that in family counseling my confidentiality and privilege, is subject to, and therefore limited by, all participating family members, confidentiality and privilege. Any request for release of information is subject to each legally competent family member's signed waiver release. I also understand that this may be limited by mandate of Federal or Oklahoma statute, Federal or State Judicial Subpoena, or, Federal or State Judicial Bench Order. Further I acknowledge the professional judgement of the Therapist, as directed by Oklahoma law, may supersede the confidentiality of all parties in the interest of client self-safety or any other person or group's risk of harm.

I have read and understand the above situations under which confidential information could be disclosed or released.

As well, I give consent, at the discretion of my Therapist to consult with Olive Branch Clinic medical or clinical staff to coordinate care and enhance treatment received.

Your signature below indicates that you have read and understand all above information, the assigned counselor has satisfactorily provided information regarding her professional credentials and consent is given to provide services to

- You Your child who is not of legal age

_____	_____
Client Signature	Print Name
_____	_____
Parent/Legal Guardian	Print Name

Address	City, State, Zip	Daytime Phone
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Dated this _____ day of _____, 20_____

As a Licensed Marital and Family Therapist, licensed by the state of Oklahoma State Board of Behavioral Health Licensure, I am required by law to furnish you with information about my professional credentials. I will be happy to discuss this information with you and /or furnish you with printed material. You may contact the LMFT office listed below for additional information (it is not necessary to give your name when requesting information). (405) 522-3696, Counselor Licensing, Oklahoma State Board of Behavioral Health, 3815 N Santa Fe Suite 110, Oklahoma City, OK, 73118.

_____	<u>OK LMFT #047</u>
Counselor's Signature	License Number

Copy accepted by client _____ Refused _____