**CONSENT TO TREATMENT & PATIENT RIGHTS**

I grant permission for the staff of Ellington Counseling Services, LLC (ECSLLC) to take any measures clinically necessary for the assessment, evaluation, and treatment (evaluation, counseling, and psychotherapy) of me, as a client.

If the client needing services at ECSLLC is a minor child, I, as the responsible adult or guardian, grant permission for the assessment, evaluation, and treatment of the child.

As a patient, you have the right to appropriate care and protection. State and Federal laws and regulations guard your confidentiality. You may also have other rights, which are listed below. Read carefully and be sure to ask ECSLLC staff any questions you have.

1. Consent to Treatment: I understand that the primary staff person(s) assigned to me will explain the nature of the assessments and treatment to be provided, the expected benefits and risks, and alternatives available. I also understand that although a reasonable standard of care will be provided, improvement, though expected, is not guaranteed. If I wish to withdraw from treatment at any time, a staff person will help me with an appropriate referral if I so choose.

2. Confidentiality and Release of Information: I understand that information concerning my contact with agency will be held confidential among my clinical team to protect my right to privacy. I further understand that such information will not be disclosed without my written permission, or that of my legal guardian, except under special circumstances such as:

a. If I threaten to injure myself or someone else;

b. When such information is required by law to be reported such as information regarding abuse, neglect, molestation, or exploitation of a minor, incapacitated adult, elder person 65 or older, or in the case of a court order;

c. For medical emergency, or

d. Use of pertinent parts of my records pertaining to treatment for the purposes of quality improvement activities.

3. I understand that I have the right to:

a. Privacy;

b. Considerate care that respects my privacy and individual needs;

c. Information about my assessments and treatment;

d. Know the names and functions of everyone who takes care of me;

e. Make my care decisions before and during the course of treatment;

f. Refuse a recommended treatment or plan of care;

g. Expect staff to treat all communications and records about my care confidentially;

h. Expect continuity of care and to be told about choices that are provided outside of this agency;

i. Appropriate recognition and consideration of my spiritual and cultural values;

j. Review my assessment and treatment records and have information provided to me, according to agency policy.

Having been informed of my rights and obligations as a patient, I hereby give my consent for assessment and treatment.

Client Signature Date

Printed Client Name Date

Parent / Guardian Signature Date

Staff Signature Date