

**CONSENT FOR TREATMENT (CLIENTS UNDER 18 YEARS)**

Part of our responsibility is to assure that you have been informed of your basic rights, responsibilities, and choices. This is all part of “informed consent to treatment”. Please read the items below and then sign at the bottom, if you consent to treatment here. This documents that you’ve been told what you need to know about our services and that you agree to treatment here. If you like, you may discuss this with your counselor before you sign.

I have received a copy of my Rights and Responsibilities as a client of Artisan Counseling (LLC), a statement of fee policies, and my counselor’s professional statement. These documents include information about the goals, methods, benefits, and potential risk of counseling as well as guidelines for an effective counseling process.

I am aware that communication with my counselor may be noted and these notes kept in a confidential file (EMR, which will be destroyed 10 years after closure or five years after attaining the age of eighteen, whichever comes later) and that, unless I authorize and sign a release of information, no information gathered nor records compiled can be shared with anyone who is not directly involved in my treatment; and I understand that my counselor may consult with other counselors, supervisors and consultants who are employed by Artisan Counseling in order to assist in my care and who are considered to be “directly involved in my treatment.” (If you wish to place restrictions on such consultation, please inform your counselor.) I also understand that family member who attend one or more counseling session with me also are seen as “directly involved in my treatment.” (If you wish to place restrictions on communications with these family members, please inform your counselor.)

With clients who are under the age of eighteen, parents/guardians normally have a right to access the record and to be informed about indications that the child/adolescent is engaged in dangerous or destructive behavior. However, therapy is most effective when the child/adolescent is able to speak freely in the therapy context, with a sense of privacy and confidentiality. Early in treatment, parents/guardians and therapist should discuss with the child/adolescent what is to be shared across generational boundaries.

| <b>Please Initial:</b> | <b>I further understand that these provisions of confidentiality are subject to the following conditions and exceptions:</b>  |
|------------------------|---|
|                        | In cases of couples or family counseling, all participants over the age of 18 must authorize any release of information about any one or more participants (however this does not apply to occasional “collateral sessions” with family members).   |
|                        | Unless directed otherwise by proper legal authorities, the consent of all parents/legal guardians is required for a counselor to provide testimony or evidence on the bases of this counseling in civil proceedings.  |
|                        | In civil proceedings, Virginia law requires my counselor to share with the proper authorities information regarding reports or actions of suicide or homicidal intent or substantial risk; reasons to suspect child abuse and/or elder abuse; and situations of life-threatening medical emergency, and that, in these and similar legally mandated instances or when these is a court order, my consent is not required. |
|                        | Under federal law, we may be required to disclose your health information to authorized federal authorities who are conducting national security and intelligence activities or providing protective services for the President or other important offices. By law, we cannot reveal when we have disclosure such information to the government.  |
|                        | In marriage, child, and/or family therapy, it may be considered necessary for effective treatment for information to be shared among those family members who participate in therapy, and additional consents may be requested;   |
|                        | Artisan staff may contact me regarding appointments and/or payments, and may leave messages with family and/or on an answering services unless I direct them not to do so; and  |

*Dedicated to the craft of individual, family, couples and group counseling*

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|  | We cannot assure confidentiality regarding the presence or statements of clients in the waiting room, hallways, or other public areas or regarding email from clients.   |
|  | When you choose to use insurance or employee assistance plans to pay for your services, you give us permission to provide information that they request for the purposes of assessment and billing.  |
|  | I understand that, although my file is the property of Artisan Counseling, I have the right to review and discuss the information in it. I am aware that I will not be deprived of any of my civil rights while in counseling at this agency, nor will I be discriminated against. I understand that I am entitled to a copy of any consent form I sign. |

| <b>I have read this form and hereby consent to treatment</b>                             |                          |                                  |  |
|--|--------------------------|----------------------------------|--|
| Print Client Name:   |                          |                                  |  |
| Client Signature:  |                          | Date:                            |  |
| Print Legal Guardian Name:   | <input type="checkbox"/> | Custodial Parent                 |  |
|  | <input type="checkbox"/> | Guardianship Order (Attach Copy) |  |
|  | <input type="checkbox"/> | Power of Attorney (Attach Copy)  |  |
| Legal Guardian Signature:  |                          | Date:                            |  |
| Print Legal Guardian Name:   | <input type="checkbox"/> | Custodial Parent                 |  |
|  | <input type="checkbox"/> | Guardianship Order (Attach Copy) |  |
|  | <input type="checkbox"/> | Power of Attorney (Attach Copy)  |  |
| Legal Guardian Signature:  |                          | Date:                            |  |
| I have discussed this form with the client(s) and provided an opportunity for questions. |                          |                                  |  |
| Counselor Signature:   |                          | Date:                            |  |