

Client rights/informed consent

I understand I have chosen to undergo therapy and that this choice is voluntary and that I may terminate at any time. I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others and in cases of child or elder abuse. I understand that there may be circumstances in which the law requires my therapist to disclose confidential information (e.g. in the case of a subpoena).

I understand that my insurance/managed care company may contact me to ensure continuity and quality of my treatment or after completion of my treatment to assess outcome.

I have read and understand the basic rights of all individuals, which include; A) the right to be informed of the various steps and activities involved in receiving services; B) the right to confidentiality under federal and state laws relating to the receipt of services; C) the right to humane care and protection from harm, abuse or neglect; D) the right to make an informed decision whether to accept or refuse treatment; E) the right to contact and consult with counsel at my expense; F) the right to select practitioners of my choice at my expense.

I understand that my therapist, my insurance representative, and my primary care physician may exchange any and all information pertaining to my therapy, to the extent that such disclosure is necessary for claims procession, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in my benefit plan.

Signature of client

Date

Signature of parent or guardian