Summit Family Counseling, Inc.

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Consent to Treatment

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know because this is your therapy. There are also certain limitations to those rights of which you should be aware. As a therapist, I have corresponding responsibilities to you.

My Responsibilities to You as Your Therapist

I. Confidentiality

Except for certain specific exceptions that are described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy without your prior written permission. Under the provisions of the Health Care Acts of 1992, I may legally speak to another health care provider or a member of your family about you without your prior written consent, but I will not do so unless the situation is an emergency. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending claims or faxing information), it will be done with special safeguards to insure confidentiality.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately. I would inform you before I took this action.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and I would explore all other options with you before I took this step.

4. If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either a) engaged in sexual contact with a patient, including yourself, or b) is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this tot their licensing board at the AR Department of Health. I would inform you before taking this step. If you are my client and a health care provider, however, your confidentiality remains protected under the law from this kind of reporting.

II. Diagnosis

If a third party such as an insurance company is paying for part of your bill, I normally am required to give a diagnosis to that third party to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. All the diagnoses come from a book titled the DSM-IV; I have a copy in my office and will be glad to discuss this with you at any time.

III. Other Rights

You have the right to ask questions about anything that happens in therapy. I am always willing to discuss alternative that might work better. If you feel that I am not the right therapist for you, you can request that I refer you to another therapist. You have the right to leave therapy at any time.

Client Consent to Psychotherapy

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed, and understand it. I understand the limits to confidentiality required by law. I consent to the release of information necessary to complete the billing process. I understand that I am responsible for the fees incurred. I understand my rights and responsibilities as a patient. I understand that I can end therapy at any time that I wish and that I can refuse any requests or suggestions made by Summit Family Counseling.

Signed:_____
Date:_____

Signed:_____
Date:_____

Witness:_____
Date:_____