PATIENT/CLIENT RIGHTS CONSENT FORM

Please read and sign below.

Living Well Counseling Services, LLC, wants you to be aware of your rights and responsibilities as a patient/client of our clinic. We ask for your INFORMED CONSENT to receive treatment. A copy of the “Patient Bill of Rights” appears in our waiting room and you have been given a copy of the “Patient Bill of Rights” to take with you. Please read this. In addition, please read the following general information about the psychotherapy process:

CONSENT TO TREATMENT:

1. The benefits of psychotherapy are to help alleviate the problems and symptoms that you present. As a client you will be involved in the formulation and evaluation of your treatment plan throughout the therapy process.

2. Psychotherapy is conducted in a professional and appropriate manner between psychotherapist and patient/client talking about the presenting problem.

3. If there is any expected side effects from psychotherapy (or medication when that is a consideration) they will be discussed with you.

4. The psychotherapist will suggest alternative treatment methods and will make referrals to other psychotherapists when appropriate or necessary.

5. The possible consequences of not receiving psychotherapy may be discussed.

6. What you say to your therapist, as well as any case notes or other records are confidential and generally will not be shared with others unless you provide written consent. However, there are exceptions to this. a) Sound ethical treatment as well as state mental health policy requires periodic review of psychotherapy performed by your therapist. These reviews will be done by other mental health professionals affiliated with Living Well Counseling Services unless you are otherwise notified. You have the right, upon your request, to meet face to face with your therapist’s clinical supervisor.

b) If your therapist has reason to believe you or someone else may be in danger of physical harm, state law and professional ethics require your therapist to take steps to protect you and/or other persons involved. This may include notification of appropriate social service and legal agencies.

Examples of such instances include:

*Danger of suicide or other self-injurious behavior
*Danger of causing physical harm to another
*Occurrence or suspicion of child abuse or neglect

CLIENT RESPONSIBILITIES:

1. The client will devote time and energy to therapy. The client will follow through with treatment recommendations. This commitment strengthens your chances of reaching the goals of treatment that you and your therapist develop.

2. Refrain from physical or other types of abusive behavior to yourself, to others or to any property.

3. Be honest regarding your thoughts and feelings about your treatment.

4. Keep appointments made. Cancellations with less than 24 hour notice will be charged to your account.

5. Stay current with your bill. Full payment is expected at time of service.

INFORMED CONSENT: I have read the above statements regarding my rights and responsibilities. I hereby give my consent to be assessed and treated by this clinic. I have discussed any concerns I might have about the above statements. I understand that this statement of consent is in effect for twelve months from the date below unless I wish to revoke it earlier.

Patient/Client Signature____ **Date**_______________

Parent/Guardian Signature____ **Date**_______________

Therapist Signature____ **Date**_______________