AUSBORN BEHAVIORAL CARE, PC

Consent for Treatment

I have been fully informed of my rights as a client of this agency, the extent and limits of confidentiality in therapy, and the goals associated with the described intervention (i.e., therapy, psychological testing, etc.). With that knowledge, I request and consent to receive the described intervention from the qualified personnel of this agency.

I understand that the staff of this agency may not disclose information about treatment to anyone outside this agency without my written consent, except as required by law to comply with a Court Order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my involvement to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed.

I understand that my clinician/therapist may work with me at this agency, or in other settings based on his/her professional judgment. I further understand that my treatment may involve my participation in individual, couple, family, and/or group counseling, and may involve homework assignments for me to do outside of therapy sessions. I agree to participate actively in my treatment, to cooperate with my clinician/therapist, and to complete required homework assignments or other activities included in my treatment.

I understand that if I participate in group counseling, a condition of my doing so is that I protect the privacy and confidentiality of other participants. I agree that if I participate in group counseling, I will not disclose information about the identity, words, or actions of other group counseling participants to anyone outside the therapy group.

I understand that my therapy may include my attendance at meetings of independent self-help, such as those involving Parent Support, Abuse Victims, Alcoholics Anonymous, Narcotics Anonymous, and/or other programs. I agree to participate in such programs if assigned and to abide by the practices of those programs regarding protecting the privacy and anonymity of other program participants.

Patient/Guardian Name:_____ **Signature:**_____ **Date:**__/__/_____

Clinician Name: _____ **Signature:** _____ **Date:**__/__/_____