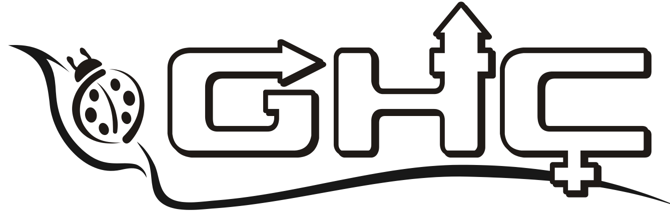

CLIENT CONSENT FORM

I acknowledge that I have received, read and understand the Client Rights information below.

Confidentiality
All communications made in session will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in couples or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. There are exceptions to confidentiality. Clinical staff is required to report instances of suspected child or elder abuse. Clinical staff is also required to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires clinical staff (and others) in certain circumstances to provide FBI agents with requested items and prohibits the clinician from disclosing to the client that the FBI sought or obtained the items.

Minors and Confidentiality:
Parents have the legal right to be appraised of the details of their minor (under the age of 18) child's treatment. Parents and other guardians who provide authorization for their child's treatment are encouraged to be involved in their treatment. However, treatment with a minor often progresses best with a good-faith agreement to confidentiality between the parents and their child so that the child can be assured of his or her confidentiality in therapy sessions. Consequently, I may discuss the *treatment progress* of a minor client with the parent or caretaker, but preferably not details that would decrease trust between the minor and me. Minor clients and their parents are urged to discuss any questions or concerns that they have on this topic

I understand that the practice of psychotherapy is not an exact science and so predictions of the effects are not precise or guaranteed. I acknowledge that no guaranties have made to me regarding the results of treatment or procedures provided by this clinician or GHC.

I understand that I may terminate my treatment at any time without consequence but that I will be responsible for payment of the services I have received.

I DO HEREBY SEEK AND CONSENT TO PARTICIPATION IN TREATMENT. I certify with my signature below that I have read, had explained to me where necessary, fully understand, and agree with the contents of this Consent to Treatment.

**All interns at GHC are under the direct supervision of Dr. David Nylund, license # LCS 14463.*

Client______________________________ Date_________

Client______________________________ Date_________

Client______________________________ Date_________

Parent/Guardian______________________ Date_________