Informed Consent for Treatment and Evaluation

You have certain rights and responsibilities when consulting a counselor for treatment or evaluation.

1. **Right to be informed regarding the terms under which treatment or evaluation will be provided**. Polices related to charges, billing third party payers, appointments, emergencies and coverage for when your therapist is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. **Right to choose the best treatment and provider.** There are a variety of professionals offering counseling and evaluations. There are also a number of different approaches to counseling. It is your right and responsibility to choose the treatment and provider that best match your needs. You also have a right to a detailed explanation of any treatment or procedure your provider may choose to use including the risks involved and the side effects if any. If you believe you are not receiving the treatment you require, then raise this concern with me and we will work to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
2. **Right to refuse or stop treatment.** Treatment may be stopped at any time and for any reason. In the case where a minor is the client, then the parent or legal guardian has the right to refuse or stop treatment for the minor. Your therapist also has the right to refuse or stop treatment, in which case you will be provided with alternative therapists. It is my hope that if you have concerns regarding your treatment you will discuss this with me.
3. **Right to confidentiality.** This means that what you tell me and what is contained in your clinical file will not be repeated or released to anyone else without your expressed permission. You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy with anyone you choose, including another provider. The content within group therapy is confidential and may not be shared with anyone outside of the group.
4. **For minors 14 to 17 years old.** Oregon law requires your therapist to have your parents involved in treatment before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. If you have been sexually abused by your parent or if you are emancipated involvement can be waived. By signing this informed consent document you:

    Authorize me to contact your parents and give them a summary of your treatment. _____ *Initial*

    Authorize me to use my clinical judgment on when to inform your parents of important issues related to your treatment. _____ *Initial*

There are, however, some limits and exceptions to complete confidentiality:

1. Child or Elder Abuse. I am required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or other appropriate state agencies.
2. Violence: If I learn that someone is about to kill or to do harm to someone else I will do my best to inform the intended victim.
3. Suicide: If I learn that a client intends to harm themselves, I will breach confidentiality to the extent necessary for your protection.
4. Non-Custodial Parents: By law, non-custodial parents can gain access to their children's records pertaining to treatment.
5. Consultation: Occasionally, it is in your best interest for me to consult with another provider regarding your treatment. This will be carried out with the utmost consideration for your privacy.
6. Insurance: Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment or other relevant information in order to authorize services and process claims. A release of information will be obtained for this.

I have read and understand my rights and responsibilities as outlined in the "Informed Consent for Treatment and Evaluation" form. Furthermore, by signing this form, I consent to received Mental Heath and/or Chemical Dependency Services to be provided by Marisha A. Senyo, LMFT.

Client signature:_____ Date: _____

Parent/Guardian Signature: _____ Date: _____