Stillwell
COUNSELING SERVICES
Individual and Family Counseling

Consent to Treatment

Please read the following information and ask your therapist about any questions you might have. Please sign acknowledging that you understand this information and give voluntary consent to participate in treatment.

***COUNSELING AND PSYCHOTHERAPY*:** Counseling and psychotherapy attempt to help you develop alternative ways of coping with problems in living. The practice of counseling and psychotherapy is not an exact science and no guarantee exists that you will automatically feel better. Although most people do feel better, some people initially feel worse.

***CONFIDENTIALITY*:** Information which you provide to your therapist is confidential and cannot be released without your written authorization; however, some limitations to confidentially exist. Under the following circumstances, information may be released without your permission to the appropriate authorities: 1) To prevent serious, foreseeable and imminent harm to you or another identifiable person; 2) If you report an incident or any suspicion of child abuse or neglect to your therapist; or 3) If you make your mental status a court issue or a judge orders release of your records.

In the event your therapist is unavailable, your therapist may give necessary information to another therapist who is on call for his or her clients needs. This information is to facilitate your treatment in your therapist's absence. **Your signature below authorizes such a release of information.**

***REGARDING HANDICAP ACCESS*:** Attempts are made to serve all clients regardless of and disability which may exist. Handicap-access offices are available for wheelchair patients. Unfortunately, restroom facilities that accommodate wheelchairs are not available. Because of the limitations of the facility, we are happy to make alternate arrangements in order to meet your therapy needs. Please discuss these needs with your therapist.

I have read, understand and agree to the above information:

Date:_____Client:_____

Date:_____Client:_____

Acknowledged by:_____Date:_____
Therapist

IF YOU WISH TO HAVE COPIES OF THE FORMS YOU HAVE COMPLETED, PLEASE INFORM YOUR THERAPIST AND COPIES WILL BE PROVIDED TO YOU.