Informed Consent for Treatment
PA COUNSELING

BEHAVIORAL SERVICES AUTHORIZATION

I agree and consent to participate in behavioral health care services offered and provided at/by PA Counseling, a mental health provider. I understand that I am consenting and agreeing only to those services that the above-named center is qualified to perform within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health providers directly supervising the services received. I authorize you to give me reasonable and proper medical care by today's standards.

Such consent does not waive my civil rights and I reserve the right to decline any treatment that I believe is not in my best interests (unless treatment has been court ordered by a judge or when refusing services poses an imminent risk of harm or death to others of myself.)

Signature: X _____ Date: X _____

Confidentiality

PA Counseling is dedicated to keeping information shared within your sessions private and confidential. In the event that we are billing a third-party, we must provide certain information concerning services rendered, diagnosis and you or your child's identity. If requested to release information with other entities/agencies, we will require a written consent. This, according to Chapter 47. State Board Of Social Workers, Marriage & Family Therapists & Professional Counselors § 47.72.

Limits of Confidentiality

I understand that my records are confidential and will not be released to other individuals or agencies without my express written consent. However I realize that certain information may be released without my authorization under the following circumstances:

- We are required by law to report suspicions of child physical and /or sexual abuse or neglect.
- We are required by law to report homicidal or suicidal intent.
- In the event of subpoena by a court, we are required to provide requested documents.

Please ask for clarification if you misunderstand anything you have read in this material. Your signature below indicates that you have read and fully understand this document.

Signature: X _____ Date: X _____

PA COUNSELING POLICY AND PROCEDURES AUTHORIZATION

I have been given a printed PA Counseling Fact Sheet provided at and by PA Counseling prior to starting counseling services. I understand that I am consenting and agreeing to the PA Counseling Policies and Procedures (making appointments, time limits, fees, rights and responsibilities, etc)

Such consent does not waive my civil rights and I reserve the right to decline any treatment that I believe is not in my best interests (unless treatment has been court ordered by a judge or when refusing services poses an imminent risk of harm or death to others of myself.)

Signature: X _____ Date: X _____