

Suzy Gadol Anderson, LCSW
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Voluntary Consent for Counseling

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, with Suzy Gadol Anderson, LCSW. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party.

Recipient's Rights: I certify that I have received the Recipient's Rights information and certify that I have read and understand its content.

Non-Voluntary Discharge from Treatment: A client may be terminated if A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts on the property and or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter.

Client Notice of Confidentiality: The confidentiality of patient records is maintained by Suzy Gadol Anderson, LCSW and is protected by Federal and/or State law and regulations. I will not disclose any personal information unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to your insurance company for payment.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is my duty to report any significant threats of harm towards oneself or others.

Professional misconduct by a health care professional must be reported by other healthcare professionals, in which related client records may be released to substantiate disciplinary concerns.

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information.

My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources. I consent to treatment and agree to abide by the above stated policies and agreements with Suzy Gadol Anderson, LCSW.

Client Signature _____ Date _____

2nd Client Signature _____ Date _____

Parent/Guardian _____ Date _____
(if client is a minor)