# *Apple Blossom Counseling*

## Informed Consent

### *Consent to Treat*

I hereby give consent for treatment under the terms described in this consent document and the HIPAA Notice of Privacy Practices. It is agreed that either of us may discontinue the treatment at any time and hat you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am the custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement. Please provider proof of guardianship.

### *Services and Availability*

Apple Blossom provides intensive and non-intensive community based counseling and support services to individuals and families who are experiencing behavioral health issues. We have practitioners who qualify as one of the following as defined by the Arizona Department of Health Services: Behavioral Health Professional, Behavioral Health Technicians, and Behavioral Heath Paraprofessionals. We work in teams or individually, depending on the needs of each individual or family. Our staff have mobile phone and are available on weekdays and weekends as agreed upon between you and the staff. We do not provide crisis services. Please contact your local crisis hotline for any crisis situations and contact 9-1-1 for life threatening emergencies. Crisis Hotline:

Maricopa County Crisis Line: 602.222.9444

### *Purpose, Limitations, and Risks*

The process of counseling usually involves working through tough personal issues that can result in some emotional and psychological pain for the client. Attempting to resolve issues that brought you to therapy may result in changes that were not originally intended. Counseling may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, and any aspect of life. Increasing structure in a child's environment can sometimes cause temporary rebellion, with the goal being decreased negative behavior. Change will sometimes be easy and swift, but more often it will be slow and frustrating. There are no guarantees that counseling or other services with yield the intended results.

### *Treatment process and rights*

Your counseling will begin with one or more sessions devoted to gathering information so that we can get a good understanding of the issues, your background, and any other factors that may be relevant. We will complete a treatment plan at this session, which outlines the goals that we will be working on in subsequent sessions. You have the right and the responsibility to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refused withdrawal.

### *Our relationship*

The client and staff member relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and staff member to spend time together socially, to bestow gifts, or to attend family or religious functions. The purpose of these boundaries is to ensure that we are clear in our roles for your treatment and that your confidentiality is maintained. If there is ever a time when you believe that you have been treated unfairly or disrespectfully please talk with us about it. It is never our intention to cause this to happen tp out clients, but sometimes misunderstandings can inadvertently result in hurt feelings. We want to address any issues that might get in the way of the therapy as soon as possible.

### *Privacy, Confidentiality and Records*

All communication and records created in the process of counseling are held in the strictest confidence. However, all Apple Blossom employees are mandated reporters of abuse and neglect. This creates limits to confidentiality. Staff must report to the appropriate government agency any alleged physical, emotional, and sexual abuse or neglect. In addition, staff have a duty to warn if a client makes a threat to another person and the threat is interpreted as causing another person imminent danger in the situation. Should this happen staff will contact the potential victim as well as local law enforcement. If Apple Blossom staff receive a subpoena for records, staff will inform you of the subpoena and will respond to it by sending the appropriate documents. Staff may also share your personal information in the event of a medical emergency.

There are also numerous circumstances when information might be released including when disclosure is required by the Arizona Board of Behavioral Health Examines, when a lawsuit is filed against us, to comply with worker compensation laws, to comply with the US Patriot Act and to comply with other federal and state laws. The rules and laws regarding confidentiality, privacy, and records is complex. THE HIPAA Notes and Privacy Practices details the considerations regarding confidentiality, privacy, and your records. It is imperative that your read and understand the limits of privacy and confidentiality before you start treatment.

If you would like to view or receive a copy of your records, please submit a written request to your staff member. The Clinical Director will review once in receipt of your request and you will receive a statement in writing from the Clinical Director either granting or denying your request. If your request is denied you have the right to appeal the decision.

While it is true that both biological parents (whether custodial or not) do have a right to view a minor's medical record, we ask that this be kept to a minimum so as not to disrupt the therapeutic process. We also ask that you do not include Apple Blossom in any custody or visitation matters as this is not included in our scope of practice. In fact, our records may not be acceptable for litigation purposes if a court determination that disclosure would be detrimental to the child. We are always willing to discuss he treatment of a minor with any interested guardian and prefer to have communication occur within the context of a family session whenever appropriate.

**I, _____, (client or legal guardian) give informed consent for treatment. I have read the document. I understand it and I have had a chance to have all of my questions answered.**

_____

Name of Client (Print) Client Signature Date

_____

Parent/Legal Guardian (Print) Parent/ Legal Guardian Signature Date

_____Cara Jones, MPA, MSW, LCSW_____

Name of Staff Member (Print) Signature of Staff Member Date