Community Counseling

Informed Consent and Limits of Confidentiality

Limits of Confidentiality:

The contents of a counseling, intake or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client. It is the policy of the Community Counseling Center not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- **Duty to Warn and Protect:**
  - When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to comply with Chapter 394, Florida Statues (The Baker Act) by notifying legal authorities when a client will not voluntarily consent to emergency treatment.
- **Abuse of Children and Vulnerable Adults**:
  - If a client states or suggests that he or she is abusing a child (or vulnerable adult) or is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.
- **Court Orders**:
  - Health care professionals are required to release records to clients when a court order has been served.

Informed Consent (please check boxes):

- ☐ **I consent to receive services from The Community Counseling Center of Empath Health.**
- ☐ **I understand that *this program does not provide emergency services* and *I have been provided with a referral resource list* that I may call in an emergency or on weekends/evenings.**
- ☐ **I understand that my *case will be closed after 30 days of inactivity or 3 consecutive "missed appointments*".**
- ☐ **I understand that if I cannot attend a scheduled appointment time, *I need to cancel within 24 hours*.**
- ☐ **I have been informed and understand the limits of client confidentiality.**

I understand that I must provide an **Emergency Contact** person while I am a client of The Community Counseling Center. I authorize the staff of The Community Counseling Center to contact:

Emergency Contact Name: _____ **Relationship**: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Client Signature: _____ **Date:** _____/____/20____

Client Printed Name: _____

Counselor Signature / Credentials: _____ **Date:** ____/____/20____

MINOR CONSENT: FOR EACH PARTICIPATING MINOR - PLEASE READ THE FOLLOWING STATEMENTS:

1. CHECK ALL STATEMENTS YOU ARE IN AGREEMENT WITH and 2. SIGN AND DATE ON BELOW

- ☐ **I understand that my child(rens) participation in the Community Counseling Center counseling is voluntary. I may discontinue any or all services upon request.**
- ☐ **I give my permission for my child(ren) to participate in counseling provided by the Community Counseling Center.**
- ☐ **I understand that all information will be held in confidence unless a *Release of Information* form is requested and signed by the parent/guardian.**
- ☐ **I understand that information collected during treatment may be used for research purposes.**

Names of Participating Children:

_____ #_____
_____ #_____
_____ #_____

Parent/Guardian Signature: _____ **Date:** _____/_____/20_____

Parent/Guardian Printed Name:_____

Counselor Signature / Credentials: _____ **Date:** ____/____/20____

OFFICE USE ONLY: **Client #** _____

Client: Last _____ **First:** _____ **Admit Date:** _____/_____/20_____

Scanned ☐ **Audited:** _____/_____/20_____