**Thrive Family Co.**

1152 2nd Avenue

Ladysmith, BC, V9G 1A1

Phone: (250) 924-4226

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**Informed Consent**

| Client Name: | DOB: | Today’s Date: |
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Welcome to Thrive Family Co. This Informed Consent document contains important information about my professional services and business policies. Please read carefully and ask questions you may have. When you sign this document, it will represent an agreement between us.

**PSYCHOLOGICAL SERVICES:**  Psychotherapy varies depending on your needs and particular problems you hope to address. There are many different methods I may use to address problems/concerns/issues. Psychotherapy calls for an active effort on your part. For therapy to be successful, you will need to work on things we talk about both during our sessions and at home.

Clients often learn things about themselves that they don’t like during sessions. Often growth cannot occur until past issues are experienced and confronted, which can cause distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices and changes that may result from therapy.

I will conduct an initial evaluation. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If not, I will provide you referrals to other practitioners whom I believe are better suited to help you. If you have questions about my techniques, we should discuss them whenever they arise.

**CLIENT RIGHTS:**

* Be treated with dignity and respect
* Know the qualification and professional experience of your therapist
* Privacy and confidentiality
* Ask questions regarding your treatment
* Know information regarding diagnosis, treatment philosophy, method, progress, prognosis, and theoretical approach.
* Participate in decisions regarding your treatment
* Know assessment results and have them explained to you in a manner that you understand
* Refuse treatment methods or recommendations
* End counseling at any time (please discuss reason for wanting to end counseling)

**CLIENT RESPONSIBILITIES:**

* Maintain your own personal health and safety
* Take an active role in the therapeutic process to include honestly sharing thoughts, feelings, and concerns
* Help plan your goals
* Follow through with agreed upon goals
* Provide accurate information regarding past and present physical and psychological problems
* Keep scheduled appointments

**CONTACTING ME:**  I am often not immediately available by telephone. I will usually not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voicemail. I will make every effort to return your call within 24 hours, except for weekends and holidays. If I will be unavailable for an extended time, I will provide you with the name of another counselor to contact.

**EMERGENCIES OR CRISES:**  I will check email and voicemail and will return your call at my earliest opportunity. If you are unable to reach me, or if you have a life-threatening emergency, immediately call 911, or go to a hospital emergency room. Your safety and well-being is my primary concern.

**CONFIDENTIALITY:**  Discussions between a therapist and a client are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: (can vary by state)

* **Abuse and neglect of children and vulnerable adults:**  If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, it is required to be reported to the appropriate social service and/or legal authorities.
* **Danger to self or others:** When a client discloses intentions or a plan to harm another person, it 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, it is required to notify legal authorities and make reasonable attempts to notify the family of the client.
* **Court orders:** Health care professionals may be required to release records of clients if ordered by the court.
* **Paternal exposure to controlled substances:**  Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
* **Client’s death:**  In the event of a client’s death, medical records may be disclosed to the medical examiner, or parents of a deceased minor.
* **Minors/Guardianship:** Parents or legal guardians have the right to access the minor records unless the therapist believes that sharing this information will be harmful to the client.
* **Professional misconduct:** Other health care professionals must report professional misconduct by another health care professional. In cases in which a health care professional or legal disciplinary meeting is being held regarding the health care professional’s actions, related records may be released in order to substantiate disciplinary concerns.
* **Other provisions:** Information about clients may be disclosed in consultations with other practitioners/professionals in order to provide the best possible therapy. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

**CONSENT TO TREATMENT**:  By signing the Informed Consent, you voluntarily agree to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time.

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Client Signature Date Print Name

I, the practitioner/professional providing clinical services, have discussed the issues above with the client and/or parent or guardian of a minor client. My observations of this person’s behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent for therapy of themselves and/or minor child.

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Practitioner/Professional Signature Date Print Name

*Add Credentials Here*