

*KN Mental Health Services
1111 Hall Road
Utica, MI 48317
586-697-0218*

INFORMED CONSENT TO PSYCHOTHERAPY/COUNSELING

This form is to document that I, _____, give my permission and
(Client)
consent to _____ to provide psychotherapy to me.
(Therapist)

THE COUNSELING PROCESS

There are both risks and benefits to counseling. While positive growth and resolution of personal issues may occur, no promises can be made about specific outcomes. You the client are largely responsible for accomplishing your outcome goals. Furthermore, counseling might open up levels of awareness that could be distressing. I understand that regular attendance will produce maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the therapist at least two weeks in advance so that effective planning for continued care can be implemented. _____ (Please initial)

CONFIDENTIALITY

Your counseling sessions are completely confidential. At no time will your personal information or records be shared or released to anyone outside of your personal therapist, except in cases which:

1. The client poses a clear and imminent danger to themselves or others.
2. The client was/is a victim or perpetrator of child/elder abuse or neglect.
3. The records are subpoenaed by a court for legal prosecution.
4. To obtain payment for services, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.
5. With appropriate consent of the client.

I understand that texting, email, cell phones and other electronic communications are not all HIPAA compliant and do not guarantee secure communications. I understand and accept the risks of using electronic means of communication. _____ (Please initial)

I know of no reasons why I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature _____ **Date** _____
(Client or parent/guardian)

Witness _____ **Date** _____