CONSENT TO TREATMENT

Client Name _____Date of Birth ____/____/____

I have received a copy of my *Client Information and Agreement* as a client of Joy Thacker counseling. This includes information on my rights and responsibilities as a client, as well as guidelines for an effective counseling process. I have had my privacy rights explained to me and have received or waved my copy. This explains how confidential medical information may be used, disclosed, or accessed according to federal law and as contained in the *Health Information Portability and Accountability Act* (HIPAA) effective April 14, 2003. I understand that it is my right to read these documents before signing this form, and that I am entitled to a copy of this and any other consent form that I sign. I am aware that communication with my counselor is noted and kept in a confidential file. I understand that, unless I authorize and sign a release of information form, it is the provider's policy to safeguard any information it gathers about me, as well as the medical records it compiles, from anyone who is not directly involved in my treatment. I further understand that, in cases of couple or family counseling, all participants over the age of 18 must authorize this release.

I understand that HIPAA mandates some exceptions to absolute confidentiality in such instances, my consent is not required. These include:
1. The counselor's right to use or disclose any medical information that may be required for purposes of carrying out treatment and related healthcare procedures.
2. The requirement that the counselor shares with the proper authorities: reports or evidence of child abuse; reports or actions of suicidal or homicidal intent; and situations of life threatening medical emergency or if a court order mandates my records.

I understand that I may request additional restrictions, beyond those stipulated in HIPAA, on the use and disclosure of my medical information, and that, while not required to agree to such requests, the counselor will cooperate as far as possible. Where there is agreement, however, the restrictions will be binding on the counselor.

I understand that, although my file is the property of the counselor's, I have a right to review and discuss the information in it, or to obtain a copy or summary of it at a reasonable charge. I am aware that the counseling relationship will not deprive me of any civil rights, nor will I be discriminated against in any way.

I have been informed of my counseling fee of $50 a session and of the payment schedule.
By signing below, I consent to treatment and acknowledge that my counselor may disclose my medical information as deemed appropriate (and according to state and federal law) to carry out treatment and related health-care procedures.

_____ _____
Signature of Client or Legal Representative Date

_____ _____
Counselor Signature Date