Groff & Associates
Professional Counseling

# Consent for Clinical Treatment & Rights Disclosure

Groff & Associates, LLC is committed to providing quality professional mental health care to all of our clients. Your treatment information is handled with the utmost care to ensure your privacy. This document is for consent for clinical treatment and to understand your client rights.

I, _____, hereby attest that I have voluntarily entered into treatment, or give my consent for myself, or the given minor or the person under my legal guardianship mentioned above at Groff & Associates, LLC, hereby referred to as the "Center". Further, I consent to have treatment provided by a licensed Marriage and Family Therapist or licensed Mental Health Counselor or Master's level Resident in collaboration with his/her approved licensed supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The Center encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

**Non-Voluntary Discharge from Treatment:** You may be terminated from the Center non-voluntarily if:

A) You exhibit any physical violence, verbal abuse, carry weapons, or engage in illegal acts at the Center and/or,
B) You refuse to comply with stipulated program rules, refuse to comply with treatment recommendations, or do not make payment or payment arrangements in a timely manner.

You will be notified of the non-voluntary discharge by letter. You may appeal this decision with the Clinical Director or request to re-apply for services at a later date.

**Client Notice of Confidentiality:** The confidentiality of client records maintained by the Center is protected by Federal and/or State laws and regulations. Generally, the Center may not say to a person outside the Center you attend treatment or disclose any information identifying you as an alcohol or drug abuser unless:

A) You consent in writing and/or,
B) The disclosure is allowed by a court order and/or,
C) The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

**Client Rights:** Violation of Federal and/or State laws and regulations by a treatment facility or practitioner is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State laws and regulations do not protect any information about a crime committed by you either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child, vulnerable adult abuse, or neglect from being reported under Federal and/or State laws to appropriate State or Local authorities.

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Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of your death, your spouse or minor parents have a right to access your records. Professional misconduct by a therapist must be reported by other therapists, in which case related client records may be released to substantiate disciplinary concerns. Legal custodial parents or legal guardians of non-emancipated minor clients have the right to access your records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about you, but will not receive any clinical information.

**Missed Appointments and Cancellations:** If you are unable to keep a scheduled appointment with your therapist, a twenty-four (24) hour advance notification is required. If this notice is not given, there is a Thirty-Dollar ($30.00) charge for late cancellations or missed appointments.

**Payment Due at Time of Service:** I acknowledge that all fees are due at the time of service and are to be made out to: Groff & Associates, LLC. Payment can be made by either by check, cash, credit/debit card, or HSA insurance card. Any nonsufficient funds (NSF) received via a check or bank/debit card will result in a fee of Thirty-Dollars ($30.00).

**Provider Rights:** My signature below indicates I have been given a copy of my rights about confidentiality. I authorize the Center to disclose client records to any listed third-party payer for the purpose of receiving payment reimbursement. This includes: insurance carriers, Employee Assistance Program (EAP) providers, and Church Assistance Program (CAP) Coordinators with affiliated churches. Your signature also indicates your understanding of the Client Rights section in this document.

In order for the Center to contact any listed third-party payer, this consent must be signed by each client to enable the Center authorization to file any claim or necessary paperwork. This signed consent also authorizes Groff & Associates, LLC to provide counseling treatment or services.

I acknowledge I have read this document and will be given a copy of the same if I request it. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources. I certify I have read this document and understand its content. I consent to treatment and agree to abide by the above stated policies and agreements with the Center.

| | |
|---|---|
| **Signature of Client / Parent / Legal Guardian** | **Signature of Client / Parent / Legal Guardian** |
| **Printed Name of Client / Parent / Legal Guardian** | **Printed Name of Client / Parent / Legal Guardian** |
| **Date** | **Date** |


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