COUNSELING, CONFIDENTIALITY AND PRIVACY PRACTICE AGREEMENT

As I begin the therapy process I agree to collaborate with my therapist and other appropriate professional staff members of MercyMed for the purpose of assessment and evaluation of my current situation and to work together to identify appropriate goals and methods of achieving them.

I understand that over the course of therapy, whatever assessments, tests, or other clinical care that is recommended will be fully explained to me and that I have the option to accept or reject such care. I understand MercyMed is committed to quality care. I am to contact the Medical Director regarding any questions about my therapist or concerns about the quality of my care.

I accept the necessity for recording and supervisory discussion of the sessions in which I participate. I give my permission for my counselor to tape record our sessions to use for review and also share these recordings with his/her supervisor for the purpose of obtaining assistance in the therapeutic process. All digital and written materials will be treated as other HIPPA information subject only to the limits of confidentiality described below.

INFORMED CONSENT AND PATIENT RIGHT TO PRIVACY

The confidentiality of patient records maintained by MercyMed is protected by federal and/or state laws and regulations. MercyMed may not disclose any information identifying a patient or his/her information unless: 1) the patient consents in writing 2) the disclosure is allowed by a court order, or 3) a counselor is required by law to disclose. When more than one client has participated in the therapy, the licensee may reveal information regarding only those clients who have consented to the disclosure. Federal/state laws require counselors to report where there is a clear and imminent danger to the client or others, in which case the counselor shall take whatever reasonable steps are necessary to protect those at risk including, but not limited to, warning any identified victims and informing the responsible authorities. This includes, but is not limited to, suspected child abuse or neglect (or vulnerable adults), prenatal exposure to controlled substances and any other potential harm to self and/or others.

I have read the above and give my consent to the counseling process. I have also read and understand the MercyMed statement regarding the limits of confidentiality. I have had an opportunity to ask questions to seek any clarification I needed about these important materials.

_____	_____	_____
Client's Name (Please Print)	Client's Signature	Date
_____	_____	_____
Client's Name (Please Print)	Client's Signature	Date

_____	_____
MercyMed witness initials	Date