CONSENT FOR EVALUATION/TREATMENT
(TO USE AND DISCLOSE HEALTH INFORMATION)

I, _____ (client/parent/guardian), voluntarily apply for evaluation/treatment at Arcadia Counseling Center, understand consent, and agree to the items listed below on behalf of _____ (self/minor).

a.) I have been provided with the intended outcome, nature and procedures involved in the proposed treatment, the risks of not proceeding and alternatives to the proposed treatment; I understand that consent may be withheld or withdrawn at any time with no punitive action taken.
b.) Limits of Confidentiality - ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, I understand that there are certain situations in which the therapist is required by law to reveal information obtained during therapy to other persons or agencies without my permission. The therapist is not required to inform me of their actions in this regard. These situations are as follows: (a) if I threaten grave, bodily harm, or death to another person, the provider is required by law to notify the appropriate parties or authorities; (b) if a court of law issues a legitimate court order (signed by a judge), the therapist is required by law to provide the information specifically described in that order; (c) If I reveal information relative to child abuse, child neglect, or elder abuse, the therapist is required by law to report this to the appropriate authority; (d) If I am in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; (e) Disclosure is required by the Arizona Board of Behavioral Health Examiners; (f) to comply with the USA Patriot Act and other federal, state or local laws, and (g) If I am seeking payment through an insurance company, the therapist will be required to reveal confidential information to them (each insurer is different in what information they require). There may be a time when paths cross outside of the therapy, and the therapist will maintain confidentiality by not making the initial gesture. It will be understood that neither party is being rude, but simply maintaining the therapeutic boundary. I am welcome to approach the therapist, although I will keep conversation minimal, again to maintain privacy. There may be a time when group members may cross paths of other group members; keep interaction to a minimum unless desired by both parties. In either case, I will be respectful by not revealing anything related to group.
c.) I consent to the use and disclosure of my protected health information (PHI) by Arcadia Counseling Center (ACC) and its staff members, for the purpose of treatment, payment and health care operations. This is a joint consent from between ACC and its staff. I understand the following: My signature on the Consent is required in order for me to receive care from ACC; I have the right to revoke this Consent, in writing, at any time, except to the extent that ACC has taken action in reliance upon this Consent;
I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of ACC. I realize that ACC is not required to agree to a restriction that I request. If, however, ACC does agree, the restriction must be honored by ACC; I have the right to review the Notice of Privacy Practices (attached) prior to signing this Consent. The Notice may be changed at any time and I can receive a copy of the revised Notice through my provider. ACC agrees to maintain my PHI in accordance with the practices in its Notice of Privacy Practices. This notice also explains my rights with respect to the use and disclosure of my PHI.
d.) Your evaluation and/or treatment may be staffed between behavioral health professionals within ACC.
e.) Treatment is individualized to specific needs and may result in emotional discomfort through the healing and recovery process.
f.) I agree to participate in my treatment planning process to the best of my ability.
g.) I understand that there is no guarantee that those treatment services prove beneficial to me.
h.) I understand that if participating in group treatment, all information discussed relating to other clients in sessions is confidential and may not be shared outside of group.

We are required by law to protect your PHI and to abide by the terms of the Notice of Privacy Practices and to provide you with information regarding ACC's privacy policies and practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any revised Notice of Privacy Practices.

I have reviewed and understand the abovementioned Consent to Treatment and/or Evaluation and to Use and Disclose Health Information, and can request to review the Notice of Privacy Practices, and hereby consent to the evaluation and treatment provided by Arcadia Counseling Center, LLC.

_____ _____
Client Signature **Date**

_____ _____
Parent/Legal Guardian Signature (if applicable) **Date**

_____ _____
Arcadia Counseling Center, LLC Signature **Date**