Paramount Development Association Behavioral Health Care Agency

Client Consent Form

Counseling is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and the trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

Confidentiality:

All interactions with counseling services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job related file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

Exceptions to Confidentiality:

- Your therapist may consult with other counselors to provide the best possible care. These consultations are for professional purposes only.

- If there is evidence of clear and imminent danger of harm to self and /or others, your therapist is legally required to report this information to the authorities responsible for ensuring safety.

- Ohio State Law requires that counselors, who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services, or other appropriate community authorities.

- A court order, issued by a judge, may require the Counseling Services staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify Paramount Development Association Behavioral Health Agency at (937) 263-8176 if you will be late. Twenty-four hours notice of cancellation allows Paramount Development Association Behavioral Health Agency to use the time for others. You will be assessed a $20.00 fee when you do not notify Paramount Development Association Behavioral Health Agency counselor of a cancellation, 24 hours before you scheduled time.

_____

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and wheat is expected for me as a client of Paramount Development Association Behavioral Health Agency.

_____ _____

Signature of Client Signature of Therapist

_____

Date

PARAMOUNT DEVELOPMENT ASSOCIATION

CONSENT FOR BEHAVIORAL HEALTH COUNSELING & THERAPY SERVICES

Client's Name:

_____

Last First MI

Date of Birth: _____ Social Security Number: _____

School: _____ Grade: _____

CONSENT FOR SERVICES

I consent for Your Name to conduct:

A Mental Health Assessment

Behavioral Health Counseling and Therapy

Community Psychiatric Supportive Treatment Services

I have received an explanation about the risks and benefits of any proposed services, alternative services and of having no services at all.

The person to be served is consenting on a:

Voluntary Basis

Involuntary Basis (court ordered)

_____ _____

Client's Name (Please Print) Client's Signature (if 12 yrs. or older)
Date

_____ _____

Parent/Guardian Name (Please Print) Parent/Guardian Signature
Date

_____ _____

Witness Signature Date