SAINT LOUIS COUNSELING

Consent to Treatment Form

Confidentiality:
I understand that the services provided to me by Saint Louis Counseling are confidential. Except under specific circumstances, information collected during interviews and sessions can only be discussed in closed supervision meetings within Saint Louis Counseling. I am aware that there are some circumstances under which Saint Louis Counseling is required or permitted by law to release information. These circumstances include instances of suspected child abuse or neglect, in situations in which there might be danger of harm to myself or others, or in response to court orders or subpoenas. I understand that in all other circumstances, however, Saint Louis Counseling will carefully maintain my privacy.

Releases:
I hereby authorize Saint Louis Counseling to release information necessary for billing, financial or chart audits, quality assurance reviews, and for collection of nonpayment of charges. This release will be valid until I am no longer receiving services at Saint Louis Counseling and my account is settled. I also understand that the release of any other information will require my written consent.

Consent to Treatment / Assessment:
I have discussed any questions with my clinician. Thus, with understanding of the above, I hereby consent to accepting assessment, treatment, and/or care from the staff of Saint Louis Counseling.

For Minor Receiving Services:
I understand that I have the right to participate in my child's treatment and to speak with my child's clinician regarding my concerns.

_____ _____

Signature of Patient / Legal Guardian **Date**

_____

Relationship to Patient

_____ _____

Signature of Staff Member **Date**