



CLIENT'S INFORMED CONSENT

* I have chosen to receive treatment services from Hope In Home Counseling for Seniors. My choice has been voluntary and I understand that I may terminate therapy at any time.

* I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

* I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

* I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

* I understand that the state and local laws require that my therapist report all cases in which there exists a danger to self or others.

* I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

* I understand that I may be contacted by my insurance provider to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

* I have read and had explained to me the basic rights of individuals seeking psychotherapy.

These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.

5. The right to contact and consult with counsel at my expense.

6. The right to select practitioners of my choice at my expense.

I understand that my therapist and insurance provider may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

Signature of Client

Date