



Consent for Clinical Treatment & Rights Disclosure

Client: _____

Groff & Associates, LLC is committed to providing quality mental health professional care to all of our clients. Your treatment information is handled with the utmost care to ensure your privacy. This document is for consent for clinical treatment and to understand your client rights.

I, _____, hereby attest that I have voluntarily entered into treatment, or give my consent for myself, or the given minor or the person under my legal guardianship mentioned above at Groff & Associates, LLC, hereby referred as: "the Center". Further, I consent to have treatment provided by a licensed Marriage and Family or licensed Mental Health Counselor or Master's level Resident in collaboration with his/her approved licensed supervisor. The rights, risks and benefits associates with the treatment have been explained to me. I understand that the therapy may be discontinued at any time be either party. The Center encourages that this decision be discussed with the treating practitioner. This will help facilitate a more appropriate plan for discharge.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Center non-voluntarily if:

- A) The client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Center and/or
- B) The client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner.

The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the President or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of client records maintained by the Center is protected by Federal and/or State law and regulations. Generally, the Center may not say to a person outside the Center that a client attends the program or disclose any information identifying a client as a alcohol or drug abuser unless:

- A) The client consents in writing and/or
- B) The disclosure is allowed by a court order and/or
- C) The disclosure is made to medical personnel in medical emergency, or to qualified personnel for research, audit, or program evaluation.

Client Right's: Violation of Federal and/or State law and regulations by a treatment facility or practitioner is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about



a crime committed by a client either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child or vulnerable adult abuse or neglect from being reported under Federal and/or State law to appropriate State or Local authorities.

Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center’s duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client’s death, the spouse or parents of a deceased client have a right to access their child’s or spouse’s records. Professional misconduct by a practitioner must be reported by other practitioners, in which related client records may be release to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client’s records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information.

Provider Right’s: My signature below indicates that I have been given a copy of my rights about confidentiality. I authorize Groff & Associates, LLC to disclose client records to any listed third-party payer for the purpose of receiving payment reimbursement, including insurance carriers, Employee Assistance Program (EAP) providers, Membership Assistance Program (MAP) Coordinators with affiliated churches, and you are indicating your understanding of your confidentiality policy with regard to this document.

In order for Groff & Associates, LLC to contact any listed third-party payer, this consent must be signed by each client to enable Groff & Associates, LLC authorization to file any claim or necessary paperwork. This signed consent also authorizes Groff & Associates, LLC to provide counseling treatment or services.

I acknowledge that I have read this document and will be given a copy of the same if I request it. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources. I certify that I have read this document and understand its content. I consent to treatment and agree to abide by the above stated policies and agreements with Groff & Associates.

I acknowledge that all fees are due at the time of service and are to be made out to: Groff & Associates. Payment can be made by either by check or cash. Any return checks will add an additional fee of \$25.

Signature of Client/Parent/Legal Guardian

Signature of Client/Parent/Legal Guardian

Date

Date