Professional Counseling Informed Consent Form

Name:	
Address:	
Phone:	Email:
Date of birth:	
Emergency contact:	Relationship:
Phone:	

Counseling is a collaborative process between the client and mental health provider. The mental health provider provides a supportive and non-judgmental environment to help clients work through their challenges and achieve their goals. This informed consent document will provide important information about the counseling services you will receive, the benefits and risks of counseling, and your rights as a client.

Counseling Services

I understand that I will be receiving counseling services from _____ . Counseling services may include individual, couple, or group therapy sessions.

The purpose of counseling is to address my mental, emotional, and behavioral concerns, and to help me develop strategies to manage my symptoms and improve my overall well-being.

Confidentiality

I understand that all information shared during counseling sessions will be kept confidential, except in the following situations:

- If it is determined that I am an immediate danger to myself or others, my mental health provider may have a duty to warn or protect those who may be at risk.
- If it is suspected that child abuse, elder abuse, or dependent adult abuse is occurring, my mental health provider is required by law to report this to the appropriate authorities.
- If I sign a release of information form, my mental health provider may share information with other healthcare providers, family members, or other individuals at my request.

I understand that my mental health provider may consult with other healthcare professionals or supervisors to provide the best possible care to me.

Limits of Counseling Services

I understand that counseling is not a substitute for medical or psychiatric treatment, and my mental health provider is not a medical doctor or psychiatrist. If my mental health provider believes that I need medical or psychiatric treatment, they may refer me to a medical doctor or psychiatrist.

I understand that counseling is not a guarantee of specific results or outcomes and that I am responsible for my own progress and success in counseling.

Risks and Benefits

I understand that counseling may involve discussing unpleasant or difficult topics, and that I may experience uncomfortable emotions during counseling sessions. However, I also understand that counseling may help me improve my coping skills, develop stronger relationships, and achieve my goals.

I understand that there may be risks associated with counseling, such as feeling more anxious or depressed initially. However, I understand that my mental health provider will work with me to address any negative side effects of counseling.

Fees and Payment

I understand that I am responsible for paying all fees for counseling services. I understand that fees may vary depending on the type of counseling services I receive.

Cancellation and No-Show Policy

I understand that if I need to cancel or reschedule a counseling appointment, I must provide at least 24 hours notice. If I fail to provide 24 hours' notice or do not show up for my scheduled appointment, I may be charged a fee.

Client Rights

I have the right to ask questions about my counseling services, and to receive answers in a way that I can understand.

I have the right to terminate counseling services at any time.

I understand that I have the right to file a complaint with the licensing board or regulatory agency in my state if I believe that my mental health provider has acted unethically or inappropriately.

I have read and understand the information provided in this informed consent form, and I agree to participate in counseling services provided by _____ .

Signature:	Date: