Advance Potential

PSYCHOLOGICAL SERVICES

INFORMED CONSENT FOR TREATMENT AND EVALUATION

You have certain rights and responsibilities when consulting a psychologist, psychiatrist, psychotherapist, social worker, or counselor for treatment or evaluation:

1. You have the RIGHT TO BE INFORMED REGARDING THE TERMS UNDER WHICH TREATMENT OR EVALUATION WILL BE PROVIDED. Policies related to charges, billing third party payers, appointments, emergencies, coverage for when your provider is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. You have the RIGHT TO CHOOSE THE BEST TREATMENT AND PROVIDER. There are a variety of professionals offering counseling, psychotherapy, psychiatric evaluations. There are also a number of different approaches to working with human issues. It is your right and responsibility to choose the treatment and provider that best match your needs and to participate in the development and periodic review of an individualized treatment plan. You also have a right to a detailed explanation of any treatment or procedure your provider may choose to use including the risks involved and the side-effects if any. If you believe you are not receiving the treatment you require, then raise this concern with your therapist or provider and s/he will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
3. You have the RIGHT TO KNOW THE QUALIFICATIONS AND TRAINING of your provider. You may request a therapist information sheet from your provider. If you have concerns, complaints, or believe a breach of professional conduct has occurred, you may contact the CEO or his designee to discuss the problem. Every attempt will be made to resolve the difficulty so that treatment may continue unhindered. If the difficulty is not resolved, you have the right to make a formal complaint to the relevant licensing agency.
4. You have the RIGHT TO REFUSE TREATMENT OR TO STOP TREATMENT at any time and for any reason. In the case where a minor is the patient/client, then the parent(s) or legal guardian has the right to refuse or stop treatment for the minor. You also have the right to refuse or stop evaluations. Your provider also has the right to refuse or terminate treatment, in which case you will be provided with alternatives. It is our hope that if you have concerns regarding your treatment or wish to discontinue, you will discuss this with your provider.
5. You have the RIGHT TO YOUR DIAGNOSIS. This means that after your initial mental health assessment, the treatment provider will provide you with your initial diagnosis or provisional diagnosis.
6. You have the RIGHT TO CONFIDENTIALITY. This means that what you tell your provider and what is contained in your clinical file will not be repeated or released by the provider to anyone else without your expressed permission (i.e. by a signed release of information). You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy or evaluation with anyone you choose, including another provider. The content within group therapy is confidential and may not be shared with anyone outside of the group.

By signing this informed consent document you:

A. Authorize **APPS** to contact your parents (if client is under age 18) and to give them a summary of your treatment.
B. Authorize your provider to use his or her best clinical judgment on when to inform your parents (if client is under age 18) of important issues related to your treatment.
C. Authorize **APPS** to release a minor's treatment records to the minor's parents upon parents' request (it is APPS' policy to require both the minor and the minor's parents to sign any release of information to anyone other than the minor's parents)

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<u>There are, however, some limits and exceptions to complete confidentiality</u>:

A. CHILD OR ELDER ABUSE: Generally, providers are required by law to report any known or suspected cases of child or elder abuse to the IL Department of Children and Family Services or other appropriate state agency.

B. VIOLENCE: If a provider learns that someone is about to kill or to do harm to someone else, s/he will do her/his best to warn the intended victim.

C. SUICIDE: If a provider learns that a client intends to harm him/herself, the provider will breach confidentiality to the extent necessary for his/her protection.

D. NON-CUSTODIAL PARENTS: By law, non-custodial parents can gain access to their children's records pertaining to treatment or evaluations.

E. SUPERVISION: If you are seeing an unlicensed therapist (e.g., a master's level counselor, psychology intern, or a psychologist resident, etc.) then it is expected that your therapist will initially present your case in a clinical staffing and also periodically review and discuss your treatment with a supervisor. You will be informed as to who the supervisor is prior to receiving treatment or evaluation.

F. CONSULTATION: Occasionally, it is in your best interest for your provider to consult other providers who are on the staff of Advance Potential Psychological Services, LLC regarding your treatment (e.g., medication issues, family issues, obtaining another's expert opinion, covering emergency phone calls, etc.). This will be carried out with the utmost consideration for your privacy. In cases where consultation with another professional outside of Advance Potential Psychological Services, LLC is required, then your written consent will be obtained.

G. INSURANCE: Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment, or other relevant information in order to authorize services or process claims. A release of information will be obtained for this if you are utilizing an insurance company.

I have read and understand my rights and responsibilities as outlined in the Advance Potential Psychological Service, LLC informed consent for treatment and evaluation form. Furthermore, by signing this form, I consent to receive Mental Health, EAP and/or Chemical Dependency Services to be provided by Advance Potential Psychological Service, LLC.

Signed: ___________________________________ Date: _____________

Client Signature (if aged 18 or older)

Signed: ___________________________________ Date: _____________

Parent/Guardian Signature

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