

INFORMED CONSENT

SAMPLE TEXT IDEAS

CAVEAT: *Counselors take reasonable steps to ensure that client understands the implications of any diagnosis, the intended use of tests and reports, and the methods, techniques and interventions of treatment.*

CAVEAT: *Throughout the counseling process as necessary, counselors inform the client of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be preformed, and clearly indicate limitations that may affect the therapeutic relationship.*

CAVEAT: *There are hundreds of interventions. A simple web search for “counseling theories” or mental health interventions” will produce multiple pages and information. What is listed below is a short sample using some very common therapies to show how to explain the process.*

INFORMED CONSENT:

EXPLAINING “CONTACT OUTSIDE THE OFFICE”

Sample text ideas for inclusion in a consent form or for verbal discussion with clients.

There may be occasions when you see your counselor outside the office. In an effort to protect your confidentiality and privacy, the counselor will not initiate conversation. At no time will counselor discuss clinical issues with you in social settings. Your relationship with your counselor is professional and therapeutic. Personal and/or business relationships undermine the effectiveness of therapy and should be avoided.

ASSIGNMENT:

Rewrite the above statement in to your own words

What would be another example of “contact outside the office”?

Write a statement regarding it

INFORMED CONSENT: EXPLAINING “GIFTS”

Sample text ideas for inclusion in a consent form or for verbal discussion with clients.

The organization I work for does not allow me to accept gifts from clients.

or...

Often, clients wish to bring a gift to their counselor. Gifts of a small monetary value, and symbolic in nature may be accepted by your counselor. Expensive gifts are exploitive in nature or could undermine effective therapeutic relations. Please understand that the non-acceptance of a gift is done so as to help maintain appropriate therapeutic boundaries. At no time does your counselor want you to feel obligated to give a gift. If you have further questions regarding this, please talk with your counselor.

or...

Our organization understands that our clients may choose to give a gift of appreciation to their therapeutic team. As a client, you are never expected to give a gift for the services you receive; however, if you wish to do so please ensure that the gift is under \$50.00 in value and is appropriate for and intended for all those involved in your care. Please do not give a gift to any one single caregiver. If you have questions or concerns regarding this matter, please speak to your counselor.

What would you do if:

A client brings you a \$200.00 gift card for an electronics store. (It's a card someone gave them and they don't want it)

A client brings you a hand-made pillow for your office? (You think the pillow is ugly)

ADDITIONAL LIMITS TO CONFIDENTIALITY

CAVEAT: This can be controversial. There are counselors who firmly believe that listing additional limits of confidentiality (aside from those that are mandatory or required by law) diminishes what counseling is about. If imposed, be sure to verbalize them to clients.

Sometimes counselors want to add additional limits of confidentiality to their consent form. (You may want to see the section on "minors" and some of the sample consents that have included the below items). A counselor can add additional limits of confidentiality to their consent form and when working with minors or other special populations, it can make sense.

SAMPLE TEXT FOR ADDITIONAL LIMITS OF CONFIDENTIALITY

In addition to 1) mandatory duty to warn/protect; and 2) CPS, APS, some typical examples are:

Risky behavior that is not mandatory (i.e.: duty to warn/protect and CPS): If you engage in and tell me about risky behaviors not covered under mandatory reporting laws, such as fire starting, severe eating disorders, self-injurious behaviors, harming animals, drug and/or alcohol use combined with safety sensitive activities, where there is a substantial likelihood of harm to yourself or others, I reserve the right to report to appropriate sources to keep you and others safe.

Criminal activities (i.e.: past murders, bank robberies, etc...) If you speak to me of your direct involvement in a past criminal offense, I reserve the right to report to appropriate sources.

Would you consider adding any of these statements?

What are additional examples?

What additional situations exist that a counselor might want to impose additional limits of confidentiality?

INFORMED CONSENT SAMPLE

DISCLAIMER: All samples & sample texts are intended as a guideline only. For use in your own setting, forms must be personalized to reflect your state's relevant laws and your own actual policies. Sample forms are designed for training purposes. Modify sample forms or sample text according your state's requirements and to the client, setting, and context of the work you do. Sample Forms and Sample Text ideas are provided "as is," without warranty of any kind; they are not intended to be a substitute for legal, ethical, or clinical advice or consultation.

SAMPLE INFORMED CONSENT

CAVEAT: For use in your own setting, forms must be personalized to reflect your state's relevant laws, ethical requirements for your licensing, and your own actual policies.

Office Policy and Disclosure Statement: Welcome to _____. It is a pleasure to assist you with your healthcare needs. This document contains important information about our professional services and business policies. It is important that you read this document carefully. When you sign this document, it will represent an agreement between us. You may revoke this Agreement in writing at any time. The revocation will be binding unless we have relied on it to take actions required of us by your insurance company, or your financial obligations to us have not been met at the time of your notice of Agreement revocation. We can discuss any questions you may have about this agreement at any time.

Quality of Care: We will make every reasonable effort within the scope of our abilities and expertise to help you resolve your presenting problems. Of course, you must understand that despite the fact that you will receive competent care by a well trained licensed counselor, there is no guarantee that the help provided will resolve your presenting problem(s). To utilize the mental health benefits of some insurance policies and ensure the quality of client care, we may ask you to complete a short questionnaire at the beginning, during, or at the end of treatment. This allows us to check the effectiveness of our work. There is no fee for this, and you may have access to the results of the questionnaire. Moreover, you have the right to decline if you so choose.

Voluntary Participation:

Your participation in this counseling experience is voluntary. You may choose not to participate and you may withdraw your consent to participate at any time. You will not be penalized in any way should you decide to withdraw from your involvement in professional counseling with me. Your signature also indicates that you are willingly consenting to receive counseling services. I too reserve the right to end the counseling relationship should it be indicated, and the necessary referral and termination processes will be followed.

It is understood that the counseling received on the part of the client is voluntary

The client is responsible for selecting their mental health practitioner and thereby mode of counseling used.

By signing at the first session, client is entering into a counseling contract with Counselor.

Client agrees to be present, talk and be honest.

As a client in a [state], you have the following rights:

- To expect that a licensee has met the minimal qualifications of training and experience required by state law
- To examine public records maintained by the Board and to have the Board confirm credentials of a licensee
- To obtain a copy of the Code of Ethics
- To report complaints to the Board
- To be informed of the cost of professional services before receiving the services
- To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: a) Reporting suspected child abuse; b) Reporting imminent danger to client or others; c) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; d) Providing information concerning licensee case consultation or supervision; and e) Defending claims brought by client against licensee
- To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services

Treatment Approach: Our treatment approach recognizes that each person is an individual with biological, psychological, sociological, and spiritual aspects of their being. Depending on your needs and preferences, we blend family systems, dynamic, solution focused, interpersonal, cognitive, and behavioral treatment approaches. We will also refer you to appropriate specialists when indicated, such as when medication is likely to be helpful, or medical testing seems necessary. We will discuss treatment goals and the proposed course of treatment with you periodically throughout your treatment. If you have any questions or concerns, please bring them to our attention. You have the right at any time to refuse treatment, change therapists, or request a change in therapy approach. You will not be discriminated against due to race, age, religion, national origin, handicap, gender, or sexual preference. Effective psychotherapeutic treatment requires openness, honesty, an attitude for collaboration, trust, and your willingness to invest both time and effort between sessions for working toward personal and/or family change. The success of treatment cannot be guaranteed by your counselor, because the outcome is, in part, your responsibility. We will utilize our experience, education, and training to work with you productively, and we will perform our services in a professionally competent, caring, and confidential manner.

Appointments: Individual treatment sessions typically last 45-50 minutes in length with the remaining 10-15 minutes devoted to treatment planning and record keeping. It is important to be on time, because your appointment will not be extended beyond the scheduled time as a result of your late arrival. Your appointment time is held exclusively for you. If you are unable to keep your appointment for any reason, you must give at least a 24-HOUR ADVANCED NOTICE to cancel. Otherwise, you WILL BE CHARGED THE FULL AMOUNT for the time reserved for you. Insurance companies will not reimburse you or us for the missed appointment. It is our office policy to attempt to contact our clients on the day prior to their scheduled appointment to confirm their appointment. This is a courtesy and not a requirement of our office staff.

Fees: Fees will be discussed at the time of our initial meeting and will be consistent with those of my colleagues practicing in this area with similar qualifications and experience and in the context of other service provision rates. I do not offer sliding scale fees. Payment is expected at the time of service, and failure to make payment will be considered a termination of the counseling relationship initiated by you and respected by me. Payment is required at the time of service.

Confidentiality: The law requires reporting of confidential information in three situations: suspected child abuse, threatened harm to self or others, or if individuals are gravely disabled and not able to care for themselves. Furthermore, based on the Uniform Healthcare Information Act, we may confer with others who are providing healthcare services to you as a means of ensuring quality and continuity of care. In most instances, confidential information can be subpoenaed by a court if you become involved in a lawsuit. We cannot be held responsible for maintaining the confidentiality of information about you should you become involved in litigation. If disclosure is required without your authorization, we will attempt to discuss the situation with you to clarify the situation and look for alternative solutions. Information to be disclosed that requires your authorization will not be released without a Release of Information form signed by you. The Release of Information form is valid for _____ days from the date of your signature, unless otherwise noted. Confidentiality does not cover sessions with two or more persons (couples or families), since we cannot assure that others present will keep the information in confidence. However, confidentiality does apply when one of those persons is seen individually. In some cases, it might be useful to your therapy for us to discuss your situation with others, such as a physician. In that case, we will seek your written permission for this exchange of information. On all occasions in which confidentiality is an issue, we will attempt to meet the ethical, clinical, and legal responsibilities we have with you.

Confidentiality of Adults: You have [privileged] or [confidential] communication with your counselor under the laws of the State of _____. That means that, with few exceptions, anything you disclose in therapy and any information we obtain about you from any source, including the simple fact that you are in treatment, is confidential and can only be disclosed to others with your written consent.

Disclosure without your authorization can be made if the disclosure is:

- To a current healthcare provider
- To a former or future healthcare provider, unless you request in writing that we not do so
- To immediate family members or any person with whom you have a close personal relationship, unless you request in writing that we not do so
- To public health authorities when required or when needed to protect the public or your safety
- To proper authorities if we should have reason to suspect that a child, a disabled adult, or an elderly person has been abused or neglected or if we feel you are a danger to yourself or others
- To licensing/certification boards if we are under disciplinary investigation

CAVEAT:

CONSENT INFORMATION REGARDING MINORS MUST BE COMPLETED BASED ON YOUR STATE'S APPLICABLE LAWS REGARDING MINORS AND THEIR RIGHTS TO HEALTHCARE.

If a minor, who is old enough to consent to counseling without parental involvement, chooses to use their parent's insurance, then the parent also need to sign the consent form.

*****You must know the laws for your state**Confidentiality of Minors***

In the case of children under ____ years of age, the parent(s) or legal guardian holds the communication privilege. This means that the parent is entitled to information about the child and so is the person who authorizes any release of information about the child. We will discuss with parents their child's general progress and case specifics if indicated. We will attempt to act in the child's best interests in deciding to disclose confidential information without the child's consent. Minors ____ years of age or older have the right to consent to mental health treatment without their parent's knowledge and they can consent to disclosure of treatment records. Thus, the consent of the minor (___ years and older) is required in order to release information, except in the situations listed below.

Disclosure without your authorization can be made if the disclosure is:

To a current healthcare provider

To a former or future healthcare provider, unless you request in writing that we not do so

To immediate family members or any person with whom you have a close personal relationship, unless you request in writing that we not do so

To public health authorities when required or when needed to protect the public or your safety

To proper authorities if we should have reason to suspect that a child, a disabled adult, or an elderly person has been abused or neglected or if we feel you are a danger to yourself or others

To licensing/certification boards if we are under disciplinary investigation

Risks and discomforts: It is possible that during our work together you might share with me some experiences that might be painful to recall. As we proceed with your goals, you might notice yourself feeling uncomfortable. This is to be expected, since change can create feelings of discomfort, and I would ask that should you notice any discomfort, you share with me that you are having that experience. It is likely that as we continue to work together, these symptoms will diminish.

Information About Your Treatment Records: We will keep a record of the mental healthcare services that we provide you. You may ask to see and/or correct that record. You may see your record or get more information about it by contacting and/or setting up an appointment with us. You may be charged an appropriate fee for the time and costs involved with an information request. Counselors in this office are not authorized to release your records to anyone without your permission unless the law authorizes or causes us to do so. If you are utilizing a third-party payer, such as an insurance company, we may be required to submit information about you to them in order to obtain reimbursement or authorization for treatment services. You will be asked to give permission for this release on the Insurance/Patient Information Form given to you with this Policy Statement. If there is any information that you DO NOT wish to have recorded in your chart, please inform the counselor.

Consultation: The competent and ethical practice of psychotherapy dictates that we participate in case consultation with other licensed professionals when necessary. Should we obtain consultation regarding aspects of your treatment, we will omit identifying information (including name, employment, etc.) so that confidentiality will be preserved to the best of our ability. Your signature on this policy statement serves as your consent that we may pursue consultation regarding your treatment without obtaining additional written consent from you to do so. Currently, we (or I) consult with:

[LIST EACH PERSON...]

NAME: License Number; Education; Focus of Work

NAME: License Number; Education; Focus of Work

Duration and termination of counseling: The amount of time you attend therapy with me will be determined by both or one of us, and can be influenced by a variety of conditions, including financial resources, achievement of determined objectives, and many other variables which are too numerous to list, but about which I will be happy to answer questions, and provide you with hypothetical examples.

Contacting Your Counselor: We are not available by telephone on evenings and weekends. If you cannot reach us, or you feel that you cannot wait for us to return your call, you should call your family physician, an emergency room at the nearest hospital, a crisis line at _____ or _____ or dial 9-1-1. If we are unavailable for an extended time, we will provide you with the name of a trusted colleague whom you can contact if necessary.

Emergencies: Should you have an emergency and are unable to contact me during my normal business hours, you should contact your Primary Care Physician or go to the nearest Emergency Room or dial 911.

Complaints: If you have any concerns or complaints about the course of your evaluation or treatment, please contact my/our office and discuss them with me/us first. You have the right to discontinue your treatment or ask for a referral to another therapist at any time. If after discussing your concerns with us you are still dissatisfied and feel you have been treated unprofessionally or unethically, you may contact the Department of Licensing at _____.

CAVEAT: MANY STATES REQUIRE THE FOLLOWING, BUT NOT ALL

Mental health professionals are required to report themselves or any other healthcare provider in the event of a final determination of an act of unprofessional conduct; and, a determination of risk to patient safety due to mental or physical condition, or if they have knowledge of unprofessional conduct by another licensed provider. Mental healthcare providers have to report a client who is a healthcare provider who may pose a clear and present danger to his or her clients. If you have questions or concerns about this requirement, please discuss them with your care provider.

Consent for treatment—the process of therapy/evaluation and scope of practice: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. [Counselor] will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc, or experiencing anxiety, depression, insomnia, etc. [Counselor] may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed.

Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, [counselor] is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. As stated, there are benefits and risks in all mental health counseling. Common risks include the following: presenting symptoms/concerns do not improve; or, they worsen. Possibly, new symptoms/concerns might arise during the therapeutic process. [Counselor] will check with you regularly as to your assessment of the benefits of counseling. Please share any concerns you have on an on-going basis with [counselor].

Termination: Ethically, the counselor always assesses the benefit of counseling to you. If at any point during psychotherapy your counselor assesses that he/she is not effective in helping you reach the therapeutic goals, or that you are non-compliant to the process, he/she is obligated to discuss this with you and, if appropriate, to terminate treatment. In such a case, he/she would give you a number of referrals that may be of help to you. If you request it, and authorize it in writing, [counselor] will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, [counselor] will assist you with referrals, and with your written consent, he/she will provide her or him with the essential information needed. You have the right to terminate therapy at any time.

We reserve the right to refuse service to anyone without reason, provided that a referral to an appropriate treatment provider is made at the time of refusal of services.

Agreement to Participate in Services: If you have any questions, please feel free to discuss them with us prior to signing this form. Your signature indicates that you have read, understand, and agree with our policies and accept responsibility for payment of our fees in accordance with our terms and conditions. Furthermore, you hereby authorize the mental healthcare provider to provide you psychological services. This authorization constitutes informed consent without exception.

REMEMBER TO:

Include appropriate lines for signature and date; Keep a copy of any document that was signed by a client in the client's file (hardcopy or electronic); Copy to client optional, unless they request a copy.

<p>What would you change? Delete? Add?</p> <p>What sample text in the above consent do you strongly agree with?</p> <p>Why?</p> <p>What sample text do you strongly disagree with? Why?</p> <p>Does this consent form have all the basic information required for "best practice" or per your state's requirements?</p> <p>What, if anything, does your state require that is not in this sample?</p>
