ASSURANCE COUNSELING, LLC

CLIENT NAME: ____

I consent to and am voluntarily seeking treatment at Assurance Counseling, LLC. The program guidelines and confidentiality have been discussed with me as follows:

I understand the following:

Information is considered confidential and my rights to privacy shall be respected by the staff of Assurance Counseling, LLC

It is my right to be informed of procedures used in therapy and treatment.

All of my care shall be rendered by qualified and trained professionals

Promises and/or guarantees cannot be offered regarding my treatment

It may become necessary to disclose your information for treatment, payment, and operations to: coordinate and manage your health care and related services; to my insurance company for determination eligibility, medical necessity, authorization or utilization review; or other internal and external auditing/licensing bodies to determine that I am receiving quality care.

Information may be released if necessary to keep myself, or others from being hurt or keep me from harming myself.

Information may be released if there is a reason to believe or suspect that child abuse or neglect has occurred.

Termination of treatment is ideally an agreement between the therapist and myself; however, I have the freedom to discontinue treatment at any time.

I agree to the following:

To respect the rights and privacy of other client's attending Assurance Counseling, LLC

Work with my assigned therapist in developing my treatment plan

I would be willing to participate in a follow-up survey to evaluate satisfaction with services I received.

The survey is confidential and no information is shared with my therapist. ☐ **Yes** ☐ **No**

I acknowledge that I have been given a complete copy of the Notice of Privacy Practices of Assurance Counseling, LLC ____________

Client's Initials

____ ____________________

Client/Parent/Legal Guardian Signature Date

____ ____________________

Witness Signature Date