Peninsula Pastoral Counseling Center
707 Gum Rock Court
Newport News, VA 23606
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CONSENT TO TREATMENT:
Clients who are under 18 years of age

Part of our responsibility is to assure that you have been informed of your basic rights, responsibilities, and choices. This is all part of "informed consent to treatment." Please read the items below and then sign at the bottom, if you consent to treatment here. This documents that you've been told what you need to know about our services and that you agree to treatment here. If you like, you may discuss this with your counselor before you sign.

I have received a copy of my *Rights and Responsibilities* as a client of the Peninsula Pastoral Counseling Center (PPCC), a statement of center fee policies, and my counselor's professional statement. These documents include information about the goals, methods, benefits, and potential risks of pastoral counseling, as well as guidelines for an effective counseling process.

I am aware that communication with my counselor may be noted and these notes kept in a confidential file (which will be destroyed 10 years after closure or five years after attaining the age of eighteen, whichever comes later) and that, unless I authorize and sign a *release of information*, no information gathered nor records compiled can be shared with anyone who is not directly involved in my treatment; and I understand that my counselor may consult with other counselors, supervisors, and consultants who are employed by PPCC in order to assist in my care and who are considered to be "directly involved in my treatment." (*If you wish to place restrictions on such consultation, please inform your counselor.)* I also understand that family members who attend one or more counseling sessions with me also are seen as "directly involved in my treatment." (*If you wish to place restrictions on communication with these family members, please inform your counselor.)*

With clients who are under the age of eighteen, parents/guardians normally have a right to access the record and to be informed about indications that the child/adolescent is engaged in dangerous or destructive behavior. However, therapy is most effective when the child/adolescent is able to speak freely in the therapy context, with a sense of privacy and confidentiality. Early in treatment, parents/ guardians and therapists should discuss with the child/adolescent what is to be shared across generational boundaries.

I further understand that these provisions of confidentiality are subject to the following conditions and exceptions:

1. In cases of couple or family counseling, all participants over the age of 18 must authorize any release of information about any one or more participants (however this does not apply to occasional "collateral sessions" with family members).

2. Unless directed otherwise by proper legal authorities, the consent of all parents/legal guardians is required for a counselor to provide testimony or evidence on the basis of this counseling in civil proceedings.

3. in civil proceedings, Virginia law requires my counselor to share with the proper authorities information regarding reports or actions of suicidal or homicidal intent or

substantial risk; reasons to suspect child abuse and/or elder abuse; and situations of life-threatening medical emergency, and that, in these and similar legally mandated instances or when there is a court order, my consent is *not* required;

4. Under federal law, we may be required to disclose your health information to authorized federal authorities who are conducting national security and intelligence activities or providing protective services for the President or other important officials. By law, we cannot reveal when we have disclosed such information to the government.

5. In marriage, child, and/or family therapy, it may be considered necessary for effective treatment for information to be shared among those family members who participate in therapy, and additional consents may be requested;

6. PPCC staff may contact me regarding appointments and/or payment, and may leave messages with family and/or on an answering service unless I direct them not to do so; and

7. We cannot assure confidentiality regarding the presence or statements of clients in the waiting room, hallways, or other public areas or regarding email from clients.

8. When you choose to use insurance or employee assistance plans to pay for our services, you give us permission to provide information that they request for the purposes of assessment and billing.

I understand that, although my file is the property of PPCC, I have the right to review and discuss the information in it. I am aware that I will not be deprived of any of my civil rights while in counseling at this center, nor will I be discriminated against. I understand that I am entitled to a copy of any consent form I sign.

I have read this form and hereby consent to treatment.

_____

Client Name(s) (Please Print)

_____

Client Signature(s) Date

_____

(Parent/Guardian Name(s), if client is a minor) (Please Print)

_____

(Parent/Guardian Signature(s), if client is a minor) Date

If you are a legal representative, please check the basis for your authority:

- o Custodial parent
- o Guardianship Order (attach copy)
- o Power of attorney (attach copy)

I have discussed this form with the client(s) and provided opportunity for questions.

_____

Counselor Signature Date