



TRAVERSE COUNSELING & CONSULTING

Traverse: To pass over, along or through

Client Rights and Responsibilities Agreement

You, as a client, have a right:

1. To ask about the credentials, education, and training of your therapist(s).
2. To expect that information about you is kept confidential unless you ask that it be shared with someone else. (Please be aware that in the case of divorce or child custody cases following marriage counseling, the court may require the therapist(s) to share information from the marriage counseling sessions.)
3. To be informed of the cost of all professional services prior to receiving the service.
4. To expect professional treatment that does **NOT** include actions with sexual overtones or innuendo.
5. To be free of any discrimination on the basis of religion, gender, race, color, or any other unlawful category.
6. To request information from the counselor about diagnosis, treatment plan, records, or other services which may be helpful to you.

Please note: Additional rights of Marriage and Family Therapy, Psychology, and Social Work clients are posted in the TCC lobby.

Client responsibility; The therapist(s) may expect that:

1. The client will complete any assignment or task agreed upon by the therapist(s) and the client.
2. No mood-altering chemical be used prior to any therapy session.
3. The client will treat the therapist with respect and in a non-abusive manner.
4. The client will adhere to rules of confidentiality concerning fellow members of a group, family member of a group, family members, and spouses. PLEASE NOTE: The above responsibility rest with each individual and the therapist(s) have little control over what is shared outside of the therapy session. However, if it becomes known that the rule of confidentiality has been broken, it will be discussed in the session, and the individual may be asked to terminate.
5. Each client sincerely enters into the therapeutic relationship with honesty and a willingness to share his/her concerns openly and directly.
6. Each client is responsible for keeping an appointment time and seeing that financial obligations are met.

Exceptions to the Rules of Confidentiality:

In general, the law protects the privacy of all communication between a client and a therapist. The therapist(s) may only release information about your treatment to others if you sign a written authorization form. You can revoke such authorizations at any time in writing. However, in the following situations, the therapist(s) is/are legally obligated to release information without requiring your authorization:

1. Therapist's duty to warn another in the case of potential suicide, homicide, or threat of imminent, serious harm to another individual.
2. Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
3. Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine, or their derivatives, THC, and excesses and habitual use of alcohol.
4. Therapist's duty to report the misconduct of mental health or health care professionals.
5. Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
6. Therapist's duty to provide parents of minor children access to their child's records. The Therapist reserves the right to decline the request for records if it may result in harm to the child or to the therapeutic relationship. In addition, the therapist will often recommend a Safe Harbor agreement for minor's therapy.
7. Therapist's duty to release records if court-ordered or bound by law.
8. Therapist's obligations to contracts (e.g. providing diagnostic information to an insurance carrier or health plan).



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Please initial each item and sign.

_____ I acknowledge that I have received, read, signed, and consent to abiding by the Client Rights and Responsibilities laid out above.

_____ I consent to treatment from Traverse Counseling & Consulting for services relating to the mental health field. I understand that I have the right to terminate treatment, in writing, at any time.

_____ I acknowledge that I have read and consent to the Notice of Privacy Policies (HIPAA) document, which explains, in detail, my rights to access my Personal Health Information and how, when, and with whom that information may be shared.

_____ I recognize that therapy has benefits and risks. I understand that therapy may involve exploration of my personal and family experiences and has the potential to be emotionally unsettling. I realize that although therapy may lead to better relationships, solutions to specific problems I may have, and/or a significant reduction of feelings of distress, there is no guarantee of any potential outcome of therapy.

_____ I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

Client (or Parent/Guardian) Name (Please Print Legibly)

Signature of Client (or Parent/Guardian)

Date