**Consent for Treatment**

Application is hereby made by the undersigned for voluntary admission and treatment to the services of El Paso as a client under the provision of Patient Rights for the State of Arizona. Voluntary admission and treatment may be made for any persons 18 years of age or older on his/her own signature. Any person under the age of 18 years of age may be admitted and treated with the consent of the minor’s parent or guardian.

All persons receiving services from this agency shall retain the rights, benefits, and privileges guaranteed by the laws and constitutions of the State of Arizona and the U.S.A., except those specifically lost through due process of law.

Involvement in treatment does not guarantee outcome. The general goals of counseling include:

* Gain a clear understanding of the presenting problem.
* Identify strengths, skills and resources to address the presenting problem.
* Encourage a more positive relationship with self and others.
* Support a more confident and hopeful attitude.
* Advocate for improved functioning at home, school, work and in the community.

I have been given a summary or full copy of my rights as a client and fully understand this document.

I understand that my treatment records may be subject to review by funding sources and licensing bodies to verify and evaluate services delivered.

I/We further agree to be actively involved in the treatment plan as prescribed by the multidisciplinary treatment team of El Paso while the aforementioned client is in treatment. I/We understand that included in such treatment plan would be my/our involvement in regular family, individual or group therapy sessions scheduled in accordance with State, Federal and/or payor source guidelines.

All communications and records that involve mental health, substance abuse and co~occurring treatment are confidential. Sharing of such information is prohibited unless appropriate written permission by the client or guardian has been freely given and the counselor agrees that release of such information is in the best interest of the client. Exceptions to confidentiality as determined by state law are as follows:

* If a counselor suspects neglect or abuse of a child or an incapacitated adult, a report may be made to Department of Child Safety or the Department of Economic Security.
* If a counselor has reason to believe a client is a danger to self or another, notification for the purpose of protection will be initiated.
* If a counselor receives a court or tribunal order from a judge, information may be subject to release.
* If any legal proceedings are initiated against a counselor or El Paso, information necessary for the response may be disclosed.

I understand that each client of El Paso is required to be charged for care and treatment provided. I have been given a copy of the current rate schedule and I understand that payment of the charges is adjustable according to my financial ability to pay. I understand that I will NOT be refused needed treatment because of an inability to pay.

Client Signature Date/Time

Parent/Guardian Signature Date/Time

During services and upon termination of services from this program, we may want to contact you regarding your status, appointment reminders, to provide you with a referral (if needed), discuss payment for subsequent services, and/or to ask you to answer some questions concerning your satisfaction regarding services received. The purpose of this information is to assure the continuity of care and to provide El Paso with pertinent statistical information. You may revoke permission for follow up at any time by providing a written notice or by refusing to participate in any questionnaire.

I hereby (circle one) GIVE DO NOT GIVE **Initial:** \_\_\_\_\_\_\_\_\_\_\_\_ Permission to El Paso to contact me by:

Telephone □Yes □No

Text □Yes □No

Letter □Yes □No

E-mail □Yes □No

Voicemail □Yes □No

for follow up, appointment reminders and to answer questions concerning my satisfaction with services and my current status.