Informed Consent

- I have chosen to receive treatment services and understand I may terminate counseling services at any time.
- I understand there is no assurance that I will feel better. Because counseling is a cooperative effort between me and my provider, I will work with my provider in a cooperative manner to resolve any difficulties.
- I understand that during the course of my treatment, material may be discussed that will be upsetting in nature and this may be necessary to resolve my problems.
- I understand that records and information collected about me will be held or released in accordance with federal and state laws regarding confidentiality of such records and information.
- I understand that state and local laws require that my provider report all cases of suspected abuse or neglect of minors or vulnerable adults.
- I understand that state and local laws require that my provider report all cases in which there exists a danger to self or others.
- I understand that there may be other circumstances in which the law requires my provider to disclose confidential information.
- I understand that my provider may be contacted by my health plan to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

If I have any questions regarding this consent form or about the services offered at Employee & Family Resources, I may discuss them with my therapist. I have read and understood the above. I have read and been offered copies of the following documents.

Client to initial next to each of the following:

_____ EFR Counseling & Evaluation Services Service Description & Program Information

_____ EFR Counseling & Evaluation Services Client Confidentiality & Privacy

_____ Client Rights & Responsibilities

_____ Telehealth Services Description

_____ Reviewed Scheduling and Payment Policies

I consent to participate in the evaluation and treatment offered to me by Employee & Family Resources. I understand that I may stop treatment at any time. I understand the risks and benefits of services, limitations of confidentiality, and my rights and responsibilities as a client at EFR. I understand that EFR staff are willing to answer any questions I may have about these written documents at any time.

I have read and understand the above.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent/Guardian/Conservator or Authorized Representative, if required Date