Franciscan HEALTH

CLIENT RIGHTS AND RESPONSIBILITIES
CONSENT TO TREAT

The process of counseling can be difficult and intimidating when seeking professional assistance. We understand this and are committed to offering the best service possible while upholding the mission and values of the Franciscan Health. To this end we ask that you read and sign the following agreement to ensure mutual goals and expectation are met.

1. Regular appointments are essential for effective therapy to take place. We ask that you arrive on time for your appointment. Each session is fifty (50) minutes long and this is the amount allotted for each client. Exceeding this time affects other clients being serviced. This will also assist in confidentiality as being on time may decrease the chances of seeing another client as you enter and/or exit the office.
2. We ask that you give us at least 24 hours notice if you need to cancel your appointment. We understand that emergencies occur and you are not always aware that you will need to cancel until the last minute. When we do not receive 24 hours prior notice of your cancellation, or you fail to show for a scheduled appointment, please understand that it will be counted as one of the free sessions for which your are eligible.
3. Your confidentiality is very important to us and we will do all that we can to protect it. Despite our best efforts, and due to the high volume of clients served in our offices, you may see or be seen by someone and we ask you to respect each other's privacy should this occur.
4. If you are the parent of a minor who is being treated and you are divorced or legally separated, you must bring in court documents that explain the rights of each parent pertaining to the medical care of the minor. EAP treatment with the minor cannot start until the documentation has been reviewed. It will also be your responsibility to inform the other parent that the minor is receiving counseling from this office.
5. If you are the parent of a minor who is being treated, we ask that you make childcare arrangements for any other children and only bring the child who is the client. This will allow you and the therapist to focus solely on treatment and maximize your counseling time.
6. You will be asked during the course of treatment to participate in a Client Satisfaction Survey. You are a valued customer and your opinion matters to us. It is an anonymous process and we encourage your candid thoughts to help us address any concern and offer the best possible service to you.
7. You should expect to be treated with dignity and respect. Every effort will be made to assist you in resolving your issues while maintaining your confidentially. Unless there is a threat or danger (i.e. suicide, homicide or child/adult abuse), we will not disclose any information without your signature and written release of information. We are committed to our mission and values and want your experience with the Employee Assistance Program to be productive and pleasant.

8. I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

9. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

10. I am aware that I may stop my treatment with this therapist at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed Name Relationship to client (If necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Therapist Date

□ Copy accepted by client/parent □ Copy kept by therapist

This is strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

For Office Use Only

Scanned to File:	**R.T.**	**B.R.**	**B.G.**	**A.P.**	**C.F.**		
	C.C.	**J.K.**	**J.L.**	**B.S.**	**N.S.**	**J.S.**	**Date:____/____/____**