Consent for Treatment

I _____ am voluntarily seeking outpatient mental health and/or substance abuse treatment with The Hope Center LLC . I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy while I am a client with The Hope Center LLC. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. My counselor will also discuss alternatives, procedures, qualifications, and drawbacks to therapy.

I _____ understand that any employee or representative of The Hope Center LLC will not diagnose, treat, advice and/or make treatment recommendations related to any medical conditions. It is our advisement that you seek medical treatment and medical advise from your primary care physician before implementing any changes to your diet, nutritional regiment, or exercise routine.

Confidentiality

While you are participating in treatment at The Hope Center LLC ,your treatment records are to remain confidential, which means The Hope Center LLC will not release treatment records without your permission. Your agreeing to release information will be evident by your signature on a "Confidentiality of Release of Information" form. See 42U.S.C. 290 dd-3 and 290ee-3 Fla State Law and 42 CFR Part 2, 491.0147 Fl.

Information about your treatment and your records are protected by federal law and regulations. If anyone participating in providing your treatment violates these federal laws and regulations , it is a crime. Anyone suspected in violation of these laws and regulations should be immediately reported to the appropriate authorities.

The counselor will release information without your permission in the event of the following:

A. The court orders your records to be released

B. You have a medical or psychological emergency and Pamela G. Wiggins, LMHC needs to disclose information to medical emergency personnel. Psychological emergencies would include you being at significant risk of harm self and others.

C. The Hope Center LLC is required by law to report suspected abuse of minors, the elderly, or disabled persons. Your counselor will report these allegations to the Department of Children and Families.

I understand that I can revoke this consent for treatment at any time, and further understand that revocation of my consent will result in termination of my treatment. _____ **Please Initial.**

My consent for treatment will automatically expire the date of which my mental health and/or substance abuse treatment services are completed or 90 days from date signed. _____ **Please Initial.**

With my signature below, I acknowledge that I have read, understand, and agree to all of the above.

Please note: We do not provide emergency services. In true crisis call 911.

_____Date:_____

Signature of Client and/or Legal Guardian

_____Date:_____

Witness Signature