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CONSENT FOR TREATMENT

I, [**ClientName**], hereby authorize **[PractitionerName]** to provide evaluation, assessment, treatment and/or psychotherapy as explained to me. I understand that while these services are intended to be beneficial, as with any treatment, there are inherent risks. During treatment, I will discuss personal issues which may bring up uncomfortable emotions such as anger, guilt, and sadness. The benefits of treatment can far outweigh this discomfort and can lead to benefits such as improved functioning, improved quality of life, better stress and emotion management, and reduced impact of pain on daily functioning. Benefits can also include improved personal relationships and reduced feelings of emotional distress. I acknowledge, however, that no warranty or guarantee can be made as to the results of my services with Alcove Mental Health LLC nor any of its individual providers.

PARTICIPATION EXPECTATIONS:

- I agree that by signing this consent, I reside in Nevada or a PSYPACT-approved state. Specifically, my state of residence is: _____.
    - I understand that if I live in any of the following states or territories of the United States, I am not eligible to receive care from Alcove Mental Health at this time: Alaska, California, Guam, Hawaii, Iowa, Louisiana, Massachusetts, Montana, New Mexico, New York, Oregon, Puerto Rico, and U.S. Virgin Islands.
- I also agree to participate in my telehealth appointments from a **single, safe location** and to not be driving and/or in transit during sessions.

CONFIDENTIALITY: I understand that discussions between myself and my service provider, as well as any records related to my care, are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to me. No information will be released without my written consent unless mandated by law.

Additionally, I understand that my service provider will follow these guidelines specific to *public settings* and *mutual connections*:

- If my provider sees me out in the community, I understand they will not initiate contact in order to maintain my privacy (e.g., so that I do not have to explain who they are or how we know each other). (Note: your provider will happily respond if you initiate.)
- If I was referred by another client or mutual connection, I am under no obligation to disclose this to my provider. If my provider is aware of any mutual connections, they will not disclose this to anyone. Similarly, if I mention knowing another client in their care, I understand my provider will not be able

to confirm or discuss that person's involvement in therapy.

Possible exceptions to confidentiality include but are not limited to the following:

- abuse of any other person
- sexual exploitation
- AIDS/HIV infection and possible transmission
- criminal prosecutions
- child custody cases
- suits in which the mental health of a party is in issue
- situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose
- a negligence suit brought by the client against the therapist, or the filing of a complaint with the licensing or certifying board.

If I have any questions regarding confidentiality, I will bring them to the attention of my provider. **By signing this Information and Consent Form, I am giving consent to the undersigned provider to share confidential information with all persons mandated by law and with the agency that referred me and the insurance carrier responsible for providing my mental health care services and payment for those services (if applicable)**. I am also releasing and holding harmless the undersigned provider from any departure from my right of confidentiality that may result.

A Note from Alcove Mental Health: as part of our commitment to client-centered care, your provider will make every effort to collaborate with and notify you about any disclosures that need to occur, especially in the case of disclosing to parties not covered by active Release of Information documentation.

DUTY TO WARN/DUTY TO PROTECT: If my therapist believes that I am in physical or emotional danger or I am a danger to another human being, I understand that my provider is required by law to contact medical or law enforcement personnel to prevent harm to me or another person, and may contact the person in danger.

CONSENT TO TREATMENT: Evaluation, assessment, treatment and/or psychotherapy as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative, and consent for treatment is thus given as noted by signature. I am voluntarily agreeing to receiving mental health assessment, treatment and services for myself, and I understand that I may stop such treatment or services at any time.

Client Signature	Date
Therapist Signature	Date