Informed Consent to Treatment

Before we begin psychological services together, there some things that you ought to know about the process and about providing informed consent.

Confidentiality

All our work together, our conversations, records and any information that you give the therapist is protected by legal privilege. This means that the law protects you from having information about you or your child given to anyone. The therapist respects your privacy and intends to honor your privilege. However, there are some exceptions to your privacy that you should understand.

Limits of Confidentiality

The therapist may use or disclose protected health information (PHI) without consent or authorization in the following circumstances:

- Child Abuse: if therapist has cause to believe that a child has been, or may be abused, neglected or sexually abused, the therapist must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.
- Adult and Domestic Abuse: If the therapist has cause to believe that an elderly or disabled person is in the a state of abuse, neglect, or exploitation, the therapist must immediately report such to the Department of Protective and Regulatory Services.
- Serious Threat to Health or Safety: If the therapist determines that there is a probability of imminent physical injury by you to yourself or others, or there is probability of immediate mental or emotional injury to you, the therapist may disclose relevant confidential mental health information to medical or law enforcement personnel.

Consent to Treatment

I, _____ hereby seek and consent to take part in the psychological treatment and authorize Dr. Cindy Orrego to perform an initial interview, therapy, and/or psychological testing on _____. (client's name)

I understand that services may include face-to-face contact interviewing and providing therapy and/or testing services with a follow-up appointment to receive the results of testing. Services may also include the psychologist's time required for the reading of records, consultations with other psychologists or professionals, scoring, interpreting the results, report writing and any other activities to support these services. I agree to help as much as I can by supplying full answers, making an honest effort and working as best as I can to make sure that the findings are accurate.

Additionally, I am aware that the practice of psychotherapy or counseling is not an exact science and that the predictions of the effects are not precise nor guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures by the treating therapist. Further, I understand that evaluation and treatment will involve discussion of personal events in my and /or my family's own history which, at times, can be discomforting and is at times very personal. I am aware that I may terminate my treatment/testing at any time without consequence.

Your signature below indicates that you have read the information in the Informed Consent to Treatment and agree to abide by its terms during our professional relationship.

_____ _____

Client's printed name Client's Date of Birth

_____ _____

Signature of Client Date

I, the psychologist or clinician, have discussed the issues above with the client or wit the minor client's parent or guardian. My observation of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent of said client or of the minor client's treatment.

_____

Signature of Psychologist

_____

Date