Beth Shorstein
Counseling Services

Consent for Treatment

I consent to receiving mental health counseling from Beth Shorstein Counseling Services. These services may include individual therapy, family or couple therapy, group therapy, diagnostic evaluations, or other standard therapy techniques.

Explanation of Confidentiality Disclosure

What you disclose to your therapist is confidential. However, in some situations information about you must be shared. I will not share any more information than required. These are the conditions under which some information concerning you and your case may need to be disclosed:

1. If insurance is being billed for treatment, the diagnosis, method of treatment and dates of visits are submitted to the insurance carrier. The carrier may also request other specific information, such as length of treatment.
2. At times, it may be beneficial for your case to be discussed in clinical consultation. If this occurs, it will be done anonymously, and no identifying information will be used.
3. By law, any abuse or neglect of a minor, elderly individual or disabled person, which has not previously been reported, must be reported.
4. Information regarding your counseling can be subpoenaed by the court. If you are or may be involved in a court proceeding, it is recommended that you discuss this with your therapist and attorney.
5. A release of information will need to be signed before I can speak with anyone of your choosing, such as a physician or family member.
6. If you are in immediate danger of harming yourself or someone else, I am required to take appropriate action in order to protect you and/or others.

I have read and understand the information above, and have discussed any questions or concerns regarding this information with my counselor. I understand my counselor will give me a copy of this form, if I request it.

_____
Printed name of client

_____
Signature of client/ date

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