Empowering Parents
Rizk Assessment and Psychological Assessments
Confidential
INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name_____ Date of Birth_____

I _____, hereafter designated as the client, request and consent to those services and treatment offered by Empowering Parents/Rizk Assessment and Psychological Assessments (RAPS), which may include therapy/counseling, consultation and assessment.

I understand that as a client of Empowering Parents/RAPS, I may be eligible to receive a services including but not limited to outpatient individual and family psychotherapy, couples therapy, group therapy, psychological assessments, autism assessments, consultation and high conflict resolution services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. I understand that the goal of the initial assessment process is to determine the best course of treatment for me. Plans and recommendations for treatment will be discussed with me and I will participate in the planning thereof. Typically treatment is provided over the course of several weeks or months. Medication services may be recommended and a referral provided.

I understand that all information that I disclose to my mental health service provider is confidential. During the course of treatment, it may be necessary for my mental health service provider to communicate with other providers. I may authorize any discussion with other providers, including but not limited to treating physicians, case managers, and other necessary individuals for the continuity of the mental health treatment I may receive. I further understand that there are specific and limited exceptions to the types of information that may be disclosed which include the following:

A. When there is a risk of imminent danger to myself or another person, the clinician is legally and ethically bound to take necessary steps to prevent danger, such as informing law enforcement or others that are in danger.
B. When there is a suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform the proper authorities.
C. When a valid subpoena and/or court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests; understand that my medical records will be released pursuant to such court order or subpoena.

I understand that a range of mental health professionals, some of whom are in training, may provide services. All professionals-in-training are supervised by licensed staff. If a professional-in-training is assigned to my case, I consent to receive services from that professional-in-training. You will be informed of such professional-in-training and will have the right to opt out.

I understand that while psychotherapy and/or medications may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects. I understand that my active participation and compliance with treatment will be an important factor to achieving a positive outcome from mental health treatment. I understand that Empowering Parents/RAPS does not guarantee a positive outcome concerning the state of my mental health.

If I have any questions regarding this consent form or about the services offered by Empowering Parents/RAPS, I should discuss them before signing this consent.

I have read, understood, and agree to abide by the provisions thereof. I have been given a copy of the **Notice of Privacy Practices, if requested**. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Empowering Parents/RAPS and I understand that I may stop treatment at any time. I understand and agree that I must inform Empowering Parents if I decide to stop treatment.

I authorize the release of any medical records or other information necessary to process insurance claims (including Medicaid claims). I also authorize payment of benefits directly to Empowering Parents for services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

_____ _____

Signature of Client, Parent, or Legal Guardian **Date**

(If the client is under 18 years of age, this agreement must be signed by a parent of guardian of the person, or by the person having legal custody of said minor.)