McDowell Mountain Counseling
Creating Changes, Strengthening Families

9915 E. Bell Rd., Suite 120, Scottsdale, AZ 85260

CONSENT FOR EVALUATION/TREATMENT AND PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Psychological Services: The purpose of psychotherapy is to identify areas of psychological and/or behavioral distress and seek solutions to or alleviation of these issues through discussion and implementation of changes both during and after session. Psychotherapy can have benefits and risks. Since the process involves discussing unpleasant and difficult areas of your life, you may experience uncomfortable feelings or emotional struggles. Psychotherapy has been shown to have many benefits and often leads to better relationships, improved feelings, reduced distress and overall improved functioning in various aspects of life. During your first few sessions, you are encouraged to carefully evaluate the information provided by your therapist along with your own impressions and whether or not you feel comfortable with the therapy plan.

Confidentiality: Information developed as part of evaluation/treatment and your treatment record is confidential but may be released to those parties as required by law, such as in cases of medical/mental health emergency, serious and eminent physical harm to self or other, abuse or neglect of child or elder, court order, insurance billing claims requirements, and where otherwise legally required. In all other situations, a properly executed authorization form is required, which may be withdrawn at any time except to the extent to which it has been acted upon. MMC has contracts with an attorney, accounting firm and collection agency. As required by HIPAA, this is a formal business associate contract which requires they maintain confidentiality of any information provided to them. Any information disclosed by MMC to these entities will only be done so as necessary to execute and resolve business issues.

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment record. Because privacy in psychotherapy is often crucial for it to be effective, particularly with teenagers, it is the policy of McDowell Mountain Counseling to keep information shared in therapy with minors private unless the minor agrees to share with his/her parent or unless the information involves the safety of the child's life or endangers someone else. General information regarding treatment progress, areas of focus and attendance is provided to parents at regular intervals.

Records Retention: For adults, patient files will be maintained for at least six years after the last date of service. For minors, patient files will be maintained either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received services, whichever date occurs later. All records will be disposed of in a fully confidential and permanent manner.

In the event of Therapist death or incapacity, all active client files will be given to a local licensed therapist to facilitate the continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records all inactive clients will be handled by a "records custodian," which may be an individual or company. The custodian will be responsible for satisfying records requests and destroying records when the legal timeframes for records retention are satisfied.

I understand that the treatment services provided by McDowell Mountain Counseling are offered with respect for the dignity and rights of the individuals and families seen. I hereby authorize McDowell Mountain Counseling to conduct an evaluation and perform treatment for myself/my child with regard to

behavioral health problems. My signature below indicates that I have read, understand and agree with the following:

(a) I have been provided with the intended purpose, outcome(s), nature and procedures involved in the proposed treatment, the risks including side effects (if any) as well as the risks of not proceeding and alternatives to the proposed treatment (particularly those offering less risk or other adverse effects). I understand that consent may be withheld or withdrawn at any time with no punitive action taken.

(b) I consent to the use and disclosure of my protected health information (PHI) by McDowell Mountain Counseling, Inc. for the purpose of treatment, payment and health care operations.

(c) My signature is required in order for me to receive care from McDowell Mountain Counseling, Inc. I have the right to revoke this Consent, in writing, at any time, except to the extent that action has been taken in reliance upon this Consent. I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations. I understand that McDowell Mountain Counseling, Inc. is not required to agree to a restriction that I request, but all agreements made by McDowell Mountain Counseling, Inc. will be honored. I have the right to review the Notice of Privacy Practices prior to signing this Consent. This Notice of Privacy Practices may be changed at any time and I can receive a copy of the revised this Notice through my Clinician. McDowell Mountain Counseling, Inc. agrees to maintain my PHI in accordance with the practices in its Notice of Privacy Practices.

(d) My evaluation/treatment may be staffed by our professionals in supervision (name and identifying information will not be shared).

(e) I have the right to participate in treatment decisions and in the development and periodic review and revision of my treatment plan.

(f) I have the right to refuse any recommended treatment or withdraw informed consent to treatment and be advised of the consequences of such refusal or withdrawal by my therapist.

(g) I have been informed of all fees I am required to pay and all refund and collections policies of McDowell Mountain Counseling, Inc.

(h) There is no guarantee that the treatment services provided by McDowell Mountain Counseling, Inc. will prove beneficial to me.

(i) I understand that any communication via cell phone or email may be heard or read by a third party, as these are not secure forms of communication. Therefore, I understand that **my therapist does not communicate clinical information via email, text, or other electronic means** and prefers to discuss clinical information or concerns only in-person or over the phone. Email may be used for scheduling and payment purposes.

For parents/guardians of children: I attest that I have the legal right to consent to treatment for this child.

I hereby consent to begin therapy.

Client's Name Printed: ____

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Signature of Client (or Parent/Legal Guardian) Date

For office use only - verification that client has read and understands informed consent document

Authorized Representative:___________________________________ Date: ____________________