SEASONS COUNSELING ORLANDO
INSIGHT • HEALING • TRANSFORMATION

331 North Maitland Ave, Unit B3
Maitland, Florida 32751
(407) 960-3938
seasonscounselingorlando.com

CONSENT FOR TREATMENT

INFORMED WRITTEN CONSENT TO PARTICIPATE IN MENTAL HEALTH TREATMENT:

Therapy is a voluntary relationship between people that work together, in part, because of clearly defined rights and responsibilities held by each person. I may withdraw from treatment at any time without penalty and the therapist reserves the right to terminate treatment if deemed ethically or clinically necessary. As a client, I have certain rights and responsibilities that are important for me to know because this is my therapy, with my well being as the goal. I agree to have my case staffed with other therapists and supervisors at Seasons Counseling Orlando. I consent to have the necessary information released in order for my therapist to provide treatment, obtain payment or assist me in obtaining reimbursement from my insurance company and to carry out health care operations as explained in the Notice of Privacy Practices, available in the lobby.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), each therapist is considered a provider or "covered entity." Under this federal law, as a prerequisite to treatment, I must also read the Notice of Privacy Practices, available in the lobby. The Notice of Privacy Practices explains in more detail my rights and how a therapist can use and share a client's information. By signing this Informed Written Consent for Treatment form, I am providing my consent for Seasons Counseling Orlando to use the Protected Health Information (PHI) for the purposes of treatment, payment and healthcare operations as described in HIPAA.

Without my signature on this Informed Written Consent form, a therapist here at Seasons Counseling Orlando cannot treat me.

CONFIDENTIALITY:

My therapist is committed to maintaining strict confidentiality of my therapy. No information can or will be told to anyone without my prior written permission (called an Authorized Release of Information form).

When the client is a minor, the confidences shared in individual sessions by a child or adolescent will be respected so that an effective therapeutic relationship can be established.

With regards to couple, family or group therapy, each of the clients present must, in writing, waive confidentiality before any records or information can be released, Seasons Counseling Orlando does not take responsibility for the actions of others.

If I request online therapy and it is deemed appropriate by my therapist, I take responsibility to provide a confidential and distraction-free space to participate in sessions. I understand that because of the very nature of the Internet, online communications—including, but not limited to, email and video conferencing – cannot be guaranteed 100% confidential and secure. Additionally, I understand that my therapist and Seasons Counseling Orlando will not be held responsible for breaches of security or confidentiality resulting from my surroundings, Internet, or other technology interference.

*There are exceptions to confidentiality mandated or implied by Florida law:

1. Where there is cause to suspect a child, adolescent, or elder has been or may be abused.
2. Where there is reasonable cause to believe that you pose risk of imminent harm to yourself.
3. Where there is a reasonable cause to believe that you pose risk of imminent harm to others.
4. When there is a valid court order compelling records or witness testimony.

(continued on the next page)

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*HIPAA has different conditions that allow your mental health information to be shared or disclosed with or without your permission (these are outlined in the Notice of Privacy Practices). Many of these conditions would contradict Florida Law, thus the law (state or federal) that is stricter in favor of protecting your mental health information and the therapist will uphold your rights, as a client.

CLIENT RECORDS:

All client records are the property of Seasons Counseling Orlando therapists and will be maintained in a locked, secure location for a minimum of seven (7) years, according to Florida's 491 Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling that regulates this profession.

I, _____, CONSENT TO PARTICIPATE IN MENTAL HEALTH TREATMENT WITH MY THERAPIST AT SEASONS COUNSELING ORLANDO AND AGREE TO ABIDE BY THE POLICIES AND PROCEDURES OUTLINED ABOVE. I UNDERSTAND MY RIGHTS AND RESPONSIBILITIES AS A CLIENT AND MY THERAPIST'S RESPONSIBILITIES TO ME.

_____ Date: _____
Client Signature

CONSENT FOR TREATMENT OF MINORS (if applicable):

I, _____, the parent (or legal custodian) of _____, give Seasons Counseling Orlando permission to provide mental health services to my child. I recognize that I have a duty to be reasonably available to provide consent to changes in my child's treatment and to participate in treatment as necessary and appropriate.

In the event of a separation of divorce, it is understood that both parents, regardless of custody, must sign this form BEFORE services can be rendered to a minor under age 18. (A Notarized Original may be sent to us by mail). As well, documentation of the custody arrangement must be provided and a copy will be kept in the file.

_____ Date: _____
Parent Signature (or legal custodian) *if treatment is for a minor child*