Pittington Counseling Services

Building Stronger Lives Together
One Step At A Time

Client Consent for Treatment

Print Client Name _____

_____ **Consent for Treatment**

I, the undersigned, authorize Pittington Counseling Services to provide substance abuse services, behavioral health and/or mental health services, consistent with the level of my needs per assessment. I certify that I fully understand the treatment process as explained to me. I have been made aware of the purpose and structure of the program to which I am being admitted and the expected length of time in treatment.

_____ **Consent for Urinalysis**

I, the undersigned, consent to provide urine samples for analysis whenever requested by Pittington Counseling Services. I understand that urinalysis may be used to evaluate my need for treatment and/or monitor my progress in treatment. I understand that visual observation of urine collection by staff may be necessary and, if conducted, will be done by a person of the same gender as the client. I understand that urinalysis results are confidential except as I have given consent for the release of this information or as legally required.

_____ **Acknowledgement of Abuse Reporting Requirements**

I, the undersigned, acknowledge that per Florida Statutes 39.201 and 415, any abuse or neglect perpetrated by a caretaker and revealed to Pittington Counseling Services during the course of intake, assessment, and treatment will require that a verbal and/or written report be submitted to the Florida Department of Children and Families Abuse Registry. Pittington Counseling Services is not responsible for determining the validity of the report.

_____ **Acknowledgement for Reporting of Communicable Diseases**

In accordance with Florida Statutes 381.0031 and 384.25, I, the undersigned, acknowledge that the Medical Director, therapist, or designee, may be required to report any communicable disease I may have, or be suspected of having, that may pose a significant threat to the general public during the course of my treatment with Pittington Counseling Services.

_____ **Acknowledgement of Other Limits to Confidentiality**

In accordance with Florida Statutes 491.0147, I the undersigned, acknowledge that confidentiality and secrecy may be waived if, based on the clinical judgment of Pittington Counseling Services and/or a licensed mental health professional, the patient or client appears to be a clear and immediate danger of physical harm to themselves, others or society. Pittington Counseling Services may communicate this to the potential victim, appropriate family member, law enforcement, or other appropriate authorities. Information may also be released if the patient or client agrees to sign a waiver to release information.

In accordance with ethical guidelines, what you discuss with the mental health counselor is kept confidential at Pittington Counseling Services except where required by law. By signing below, I confirm that I have read and fully understand this consent form.

_____ _____

Client / Parent / Guardian Signature Date

_____ _____

Witness Signature Date