**Client Consent Form**

**NAME OF MEDICAL SOCIETY**

**NAME OF PROGRAM**

**INFORMATION FOR PHYSICIANS**

The purpose of this document is to inform you of your rights and responsibilities when participating in the NAME OF PROGRAM’s (NOP) counseling services. Please read it carefully and ask your therapist to explain anything you may not understand.

The therapists who provide services to the NOP are licensed in the state of XXXX. As licensed therapists, they adhere to XXXX state laws and regulations when providing psychological services. Therapists are licensed for the protection of their clients. Licensing assures the competence of the professional and serves as complaint/discipline recourse monitored by the RELEVANT STATE BOARD.

Funding for the NAME OF PROGRAM is provided by the MEDICAL SOCIETY and NAME FUNDERS. However, NAME OF MEDICAL SOCIETY/ABBREVIATION staff and administration will not have access to any information about physicians who receive services through the program. NAME OF MEDICAL SOCIETY/ABBREVIATION will gather aggregate data in order to track utilization of this program. In addition, any research involving the PWP will use only aggregate data. No identifying information will be released without signed consent by the physician.

If a physician is, or appears to be, having problems that may impair patient safety or is demonstrating unprofessional behavior which may be a risk to patients, the physician will be asked to take medical leave and seek a different level of care. If the physician is, or appears to be, demonstrating symptoms of substance abuse/dependency, a referral may be facilitated to appropriate treatment or to the STATE PHYSICIAN HEALTH PROGRAM or Similar Program.

As a client of a licensed therapist, you have certain rights, which include:

1. **The Right to Confidentiality.** Statements made during counseling are in confidence, protected by both state and federal laws. If the therapist needs to disclose any identifying information, a written release signed by the physician will be obtained.

In order to provide the highest quality service, when clinically indicated, the treating therapist may consult with other PWP providers. However, during these consultations, names and other identifying information will not be disclosed without your consent.

Under certain circumstances, the treating therapist may have to break confidentiality: It is legally required that they act to prevent physical harm to yourself or others when there is a ‘clear and imminent’ danger. They will report cases of ongoing child, elder, or disabled abuse. Confidential information may also be disclosed in the event of a medical emergency or when required to do so by a court subpoena.

As noted above, in the event that a physician is, or appears to be, at risk of impairing patient safety, the therapist will ask the physician to take a medical leave. If a physician is, or appears to be, experiencing significant substance abuse/dependence, the therapist may refer to the STATE PHYSICIAN HEALTH PROGRAM or Similar Program, or facilitate referral to the appropriate treatment provider.

A minimal confidential paper record of your counseling will be maintained by the treating therapist. These files will be locked and the privacy of these records will be protected within the limits of the law. However, in the event of an emergency, we may release information necessary for your emergency medical care.

1. **The Right to Refuse Counseling.** You may request a change in the provider of counseling, and referral to another therapist in the PWP. Referral to a psychiatrist or another mental health professional will be at your own cost. You may discontinue all counseling. Physicians have the responsibility to obtain psychological services which best meet their needs.
2. **The Right to Full Disclosure of Fees.** PWP coaching and counseling services are supported by the NAME OF MEDICAL SOCIETY/FOUNDATION. Psychological counseling is provided free of charge, up to X (X) sessions in any 12-month period. No insurance will be billed, unless desired by the physician to continue treatment after X sessions per 12-month period.

**Canceling/Rescheduling Appointments:** Please contact the treating therapist as soon as possible when you learn that you are unable to meet at the scheduled time. This is important in order to cost effectively offer appointments through the PWP.

Call the Medical Society during normal office hours at 555-555-5555. Please provide 24- hour notice to cancel or reschedule (48 hours’ notice is preferred**). You will be charged a fee for late cancellations and no-shows.**

If your treating therapist is unavailable due to illness or vacation, coverage for urgent care with another PWP therapist will be available. You will be provided with the name and contact information for another NAME OF PROGRAM provider.

**Telephone Calls and Emergencies:** For urgent needs, please call your XXXX. In the event of an emergency, call 911 or go to the nearest hospital emergency room.

I have read the above information and understand the policies of the NAME OF MEDICAL SOCIETY AND NAME OF PROGRAM’s counseling services. I have discussed this information with the treating therapist and have received a copy of this document.

**Notice of Privacy Practices Consent to Use or Disclose Clinical Information**

I authorize NAME OF PROGRAM providers to disclose my health and clinical information, if necessary, for the purposes of treatment (including services provided by this Program) while providing care to you, coordinating or managing your care, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this Program as an on-call professional.

Verify that you have received a copy of the Notice of Privacy Practices by initialing here: \_\_\_\_

**I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that this office has already used or disclosed the information in reliance on this Consent.**

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Physician Signature Date

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_