NAME OR ABBREVIATION OF MEDICAL SOCIETY
NAME OF PROGRAM

INFORMATION FOR PARTICIPANTS AND CONSENT FOR SERVICES

The purpose of this document is to inform you of your rights and responsibilities when participating in the NAME OR ABBREVIATION OF PROGRAM counseling services. Please read it carefully and ask your psychologist to explain anything you may not understand.

The therapists who provide services to the NAME OF PROGRAM are licensed in the state of XXXX. As licensed counselors, they adhere to state laws and regulations when providing counseling services. counselors are licensed for the protection of their clients. Licensing assures the competence of the professional and serves as complaint/discipline recourse monitored by the XXXX State Board of Examiners of Psychologists.

Funding for the NAME/ABBREVIATION OF PROGRAM is provided by the MEDICAL SOCIETY OR FOUNDATION. However, XXMS staff and administration will not have access to information about services provided to participants through the program. NAME OF MEDICAL SOCIETY will gather aggregate data in order to track or research utilization of the NAME/ABBREVIATION OF PROGRAM. No identifying information will be released without signed consent by the participant.

If, in the professional judgment of the psychologist, the counseling or other services needed by a participant in the NAME/ABBREVIATION OF PROGRAM are outside the psychologist's scope of practice, the participant will be referred as deemed appropriate by the psychologist to resources or providers approved by the NAME/ABBREVIATION OF PROGRAM. If the participant is, or reasonably appears to be, demonstrating behavior that constitutes an imminent threat to public safety and/or the safety of his/her patients or clients, the participant will be asked to cease practice and seek another level of care for guidance and treatment. If a participant is, or reasonably appears to be, demonstrating symptoms of substance abuse/dependency, a referral may be facilitated to the STATE PHYSICIAN HEALTH PROGRAM.

As a client of a licensed psychologist, a participant will have certain rights, which include:

1. **The Right to Confidentiality.** Statements made during counseling are in confidence, protected by both state and federal laws. In order to provide the highest quality service, when clinically indicated, the treating psychologist may consult with other NAME/ABBREVIATION OF PROGRAM providers. However, during these consultations, names and other identifying information will not be disclosed without consent. If the counselor needs to disclose any participant identifying information in these circumstances, a written release signed by the participant will be obtained.

   The treating counselor is required by law to report certain circumstances including child abuse, vulnerable adult abuse, or if the patient is a danger to self or others. Confidential information may also be disclosed in the event of a medical emergency or when required to do so by a court order.

   As noted above, in the event that a participant is determined to be an imminent threat to public safety and/or the safety of patients, the counselor will ask the participant to cease practice and seek another level of care. Further, if a participant is, or appears to be, experiencing significant substance abuse/dependence, the counselor will refer to the STATE PHYSICIAN HEALTH PROGRAM. These two (2) instances may necessitate the release of potentially confidential information to another

healthcare provider. In those instances, written consent for the release will be required. The transfer of care will terminate participation in the NAME/ABBREVIATION OF PROGRAM.

A minimal confidential paper record of counseling will be maintained by the NAME/ABBREVIATION OF PROGRAM counselors. 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 a medical emergency, information necessary for a participant's emergency medical care may be released.

2. **The Right to Refuse Counseling.** A participant may request a change in the provider of counseling and referral to another therapist in the NAME/ABBREVIATION OF PROGRAM. Referral to a psychiatrist or another mental health professional outside the NAME/ABBREVIATION OF PROGRAM will be at a participant's own cost. A participant always has the right to discontinue all counseling and/or participation with NAME/ABBREVIATION OF PROGRAM.

3. **The Right to Full Disclosure of Fees.** NAME/ABBREVIATION OF PROGRAM counseling services are supported by the NAME OR ABBREVIATION OF MEDICAL SOCIETY. Up to XX (X) sessions of psychological counseling in any 12-month period is provided free of charge. No insurance will be billed, unless desired by the participant to continue treatment after eight sessions within a 12-month period.

Canceling/Rescheduling Appointments: Please contact the counseling psychologist 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 NAME/ABBREVIATION OF PROGRAM. **Late cancellations and no-shows, as defined by the treating psychologist, will be billed to you at the NAME OR ABBREVIATION OF MEDICAL SOCIETY's cost ~~of~~ $XXX/hr.**

If the therapist providing counseling is unavailable due to illness or vacation, coverage for urgent care with another NAME/ABBREVIATION OF PROGRAM psychologist will be available. You will be provided with the name and contact information for another NAME/ABBREVIATION OF PROGRAM provider.

Telephone Calls and Emergencies: It is anticipated that counselors contracting with NAME/ABBREVIATION OF PROGRAM will provide contact instructions. In the event it is necessary, you may directly contact the NAME/ABBREVIATION OF PROGRAM at any time by calling the 24-hour support line at XXX-XXX-XXXX and identifying yourself as an NAME OR ABBREVIATION OF MEDICAL SOCIETY member. This support line will be reviewed and answered during regular office hours. In the event of an emergency, call 911 or go to the nearest hospital emergency room.

Membership: The NAME OR ABBREVIATION OF PROGRAM is provided to active and retired dues-paying members of the NAME OR ABBREVIATION OF MEDICAL SOCIETY as well as member Residents. If, during the course of counseling, a participant's membership in the Society terminates, lapses, is not renewed, or is not in force for any reason, NAME OR ABBREVIATION OF MEDICAL SOCIETY shall invoice the physician at the rate of $XXX/hr. for COUNSELING services received during the period of non-membership.

Your signature below verifies that you have read the above information and understand the policies of the NAME OR ABBREVIATION OF MEDICAL SOCIETY counseling services, you have discussed this information with the treating therapist, and you have received a copy of this document.

_____ _____

Signature of Participant **Date** 2