# **CONSENT FOR SERVICES**

**Statement of Confidentiality**

It is the policy of Foundations for Change, LLC to protect to the maximum extent possible the privacy of every client. Generally, no one will be given any information about either you or services furnished to you without your prior written authorization or consent. There are, however, some circumstances which require the disclosure of information without your consent.

Briefly these are:

1. When mandated by state or federal law (i.e. suspicion or knowledge of child abuse or neglect)
2. When there is an imminent risk or serious threat of physical harm to self or to others (including suicidal or homicidal thoughts)
3. When specifically ordered by a court of law

Most staff members will periodically and anonymously discuss your treatment with a member of this practice, again to ensure good quality of service. Members of this practice are obligated to follow laws of confidentiality.

**Emergencies**

In the event of a crisis, call the Life Crisis Hotline (314-647-4357) or go to the nearest Emergency Room or call 911. Your therapist will be glad to further discuss details with you.

**Signature**

I am 18 years of age or older, or, I have legal custody of this minor child(ren). I understand and accept the above information and I authorize these services.

Client’s name if under 18\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client signature or Guardian (if under 18) Date

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Clinician signature Date