



**INTERFACE-SAMARITAN COUNSELING**

**Client Consent for Services**

I, \_\_\_\_\_ give consent for me or my child, \_\_\_\_\_ to receive services from Interface-Samaritan Counseling Centers (ISCC) until closure of the therapeutic relationship. If I am referring my child for services, I certify that I have legal responsibility and am authorized to seek treatment for this child and that no additional person is also required to authorize treatment.

I understand that as an ISCC client, I have the right to:

- ❖ Be treated with dignity and respect without discrimination, abuse, neglect, or exploitation.
- ❖ Give input about my treatment.
- ❖ Request an explanation of the benefits, alternatives, and risks of my treatment.
- ❖ Refuse treatment and receive an explanation of potential consequences.
- ❖ Request an explanation of my therapist’s title and qualifications to provide treatment.
- ❖ Seek, at my own expense, review of my treatment by another professional.
- ❖ Confidential treatment of my records and access to them following ISCC’s policies and procedures for accessing records.
- ❖ Make a complaint about my treatment without this being used against me.
- ❖ Request a copy of this statement of rights and responsibilities.

I understand that as a client of ISCC, I am responsible for:

- Communicating openly and honestly with my therapist.
- Asking questions and clarifying what I do not understand.
- Reporting significant changes that impact my treatment.
- Discussing with my therapist the decision to discontinue treatment.
- Paying for services. Payment for each session is due at the time that services are rendered unless contracts with third-party payers, e.g., managed care companies, specify alternative arrangements.

**I will pay for any appointment that I do not keep unless I cancel at least 24-hours in advance of the scheduled time.**

If court reports, appearances, or consultations are necessary in association with treatment at ISCC, I will give advance notice and I will pay in advance for these services.

Treatment records and information that I convey to ISCC staff remain confidential and will be released only with my written consent unless required by applicable law. (Reporting alleged or suspected incidents of child abuse, elder abuse, or intended harm to self are mandated by the Texas Family Code.)

I authorize the release of information needed by third-party payers, e.g., managed care companies, churches, EAP’s, to fund payments for services rendered.

I authorize payments by third party payers to ISCC.

\_\_\_\_\_  
Client/Parent/Guardian/Managing Conservator Date

\_\_\_\_\_  
Therapist Date