

FRC CLIENT CONSENT TO TREATMENT and CONFIDENTIALITY LIMITS CONSENT TO TREATMENT SECTION

I, the undersigned, hereby voluntarily give full consent to evaluation, treatment, and recommendations by John Garlock, Ph.D., LPC, LMFT, LCDC. I understand that I will develop a written service plan with Dr. Garlock that includes the reasons and purposes and goals and techniques/procedures for the services that I will receive. This will be explained to me during my initial session. I understand that therapy is not an exact science and no guarantees have been made to me regarding the outcome of treatment or services that I receive. I understand I have a right to be treated with respect in a safe and humane environment. I understand that services are available to me regardless of my race, religion, gender, ethnic background, disability or sexual orientation. I have the right to receive services that address my needs and an explanation of any limitations of those services, including risks involved. I have the right of free communication within the constraints of treatment with full explanation of restrictions documented in my record or full explanation as to why this may not be in my best interest. I have been informed of the necessary procedure to register a grievance regarding my services.

The law protects the privacy of most communications between a patient and a mental health provider. In most situations, the provider can only release information about your treatment to others upon receipt of a signed Authorization Form. My consent to treatment allows me, during the course of treatment, to consult with other mental health professionals regarding your treatment. During consultation, every effort is made to avoid revealing the identity of any patient. The other professionals are also legally bound to keep the information confidential. Confidentiality exceptions are listed on the next page of this document. If you have any questions, I will be happy to answer them for you.

I am aware that my therapist employs administrative staff, and also contracts with outside services, such as managed care health plans, insurance companies, and billing services. All health care entities are required by law to protect your privacy. This administrative staff has been trained in protecting my privacy and has agreed not to release any information outside of the practice without the consent of Dr. Garlock. Outside services, as required by law, have contracted to maintain the confidentiality of this data. I contract with Mrs. Anissa Weiss to answer my telephone and to schedule appointments and to verify intake and third party payment information. I contract with Mrs. Carolyn Michaels of Claims Connection to prepare and submit claims to your insurance company. Please contact Anissa if you would like more information about either her or Carolyn or if you have questions about this policy.

I understand it is my responsibility to prepare for each session, to be open to addressing any concerns I may have, give honest and appropriate feedback, and to be on time for our sessions. My responsibilities include being prepared for sessions as requested, being honest with you, and being on time. I am also responsible for participating fully in the sessions, including turning off any pagers, cell phones, or other devices that may interrupt the flow of the session, and for notifying the office at least 48 hours in advance of any appointment cancellation as possible. I ask that you come to your sessions being prepared to work honestly and openly on your presenting concerns and issues that you complete any and all forms or homework that I might provide to you in a timely manner and that you inform me when you believe that your concerns and issues have been completed addressed and resolved.

THERAPEUTIC RELATIONSHIP AND CONFIDENTIALITY LIMITS SECTION

Although our sessions may be very intimate, psychologically speaking, it is important for you to realize that we have a professional relationship and not a social one. Our contact will be limited to sessions that you will arrange with me in my office setting. You may learn a great deal about me as we work

together during our sessions. However, it is important for you to remember that you are experiencing me in a professional role. If we should meet in any circumstance outside of my office (stores, movie theaters, etc.), I will not acknowledge you unless you address me first, to provide you with the utmost confidentiality. Additionally, as ours is a professional relationship, gifts and gratuities will not be accepted.

The law requires that confidentiality be broken in certain cases. Those cases are as follows:

- 1) If the therapist believes a client to be a danger to the client or to another person.
- 2) If the therapist is given information on abuse or neglect of a protected class, i.e., child, elderly or disabled person.
- 3) If a court order or other legal proceeding or statute requires disclosure.
- 4) If the therapist or therapist's family is being stalked, harassed, or otherwise endangered by a client.

I understand that if I am using insurance or an EAP to pay for all or part of the cost of my treatment, they may have access to otherwise confidential information. If I would prefer this information not be provided to insurance or EAP, I may choose to self-pay the therapy fees.

I hereby authorize Dr. John Garlock to receive payments directly from my insurance company/EAP for services received by me.

PLEASE COMPLETE AND RETURN AT THE TIME OF YOUR FIRST SESSION

Signature	Printed Name	Soc. Sec. No.	Date
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If a child, guardian/caretaker signs here Printed Name

John Garlock, Ph.D., LPC, LMFT, LCDC+

Please be aware that I do not accept child custody cases, spousal abuse cases, and sexual abuse perpetrator cases, as I am not trained in these areas. I also do not accept any case that involves legal proceedings or attorney involvement. If you require assistance with any of these issues, please let me know and I will attempt to refer you to an appropriate provider.