ALPINE
counseling services, llc

INFORMED CONSENT FOR ADULTS

I understand that information provided within the counseling relationship will be strictly confidential. However, exceptions to confidentiality include the following:

1. If there is a danger to self or others. Confidentiality may be broken in order to protect self or other from harm. _____Initials

2. Suspected cases of child abuse or neglect; suspected cases of abuse or neglect of an elder or an adult who is disabled. By law, information suggesting possible abuse or neglect must be reported to law enforcement, State's Attorney, or the Department of Social Services. _____Initials

3. Information regarding diagnosis, treatment plan, etc. will be provided to insurance companies unless otherwise specified. _____Initials

4. In instances of delinquent accounts, billing information will be provided to a third party for collection purposes. This will only take place after a final notice has been issued by Alpine Counseling Services, LLC and no response has been received within the allowed time frame. _____Initials

5. In instances where the court shall order the disclosure of otherwise privileged information. _____Initials

6. In some instances it is helpful to consult with another Alpine Counseling Services, LLC therapist regarding the treatment of a client. Please initial below regarding the possible consultation of your treatment.

☐ I give my therapist permission to consult with another therapist regarding my treatment. _____Initials

☐ I do not give my therapist permission to consult with another therapist regarding my treatment. _____Initials

7. If I have provided an email address to communicate via email I understand and accept the risk of possible authorized and/ or unauthorized access to information disclosed through unencrypted email. _____Initials

My signature indicates that I understand and agree to the above.

Signed: _____ Date: _____

Witness Signature: _____ Date: _____
Alpine Counseling Services, LLC