### CONSENT TO THERAPY AND CONFIDENTIALITY STATEMENT

 In compliance with the ethical and legal guidelines delineated by the National Board of Certified Counselors (NBCC) and American Mental Health Counseling Association, my counselor has explained that my participation in therapy is completely voluntary and confidential. In signing this document, I provide my voluntary consent to participate in therapy/counseling for myself and/or my minor child. I understand that I may refuse and/or terminate services for myself and/or my minor child at any point during the counseling process, without adverse repercussions between this agency and myself.

 I also understand that Scott D. Walls, MA, LIPC, CCMHC will maintain protected health information records relevant to therapy, as well as information obtained through consultation with other professionals. I understand that these records are restricted to the internal use of Scott D. Walls, MA, LIPC, CCMHC. and their confidentiality will be strictly maintained at all times. I understand that Scott D. Walls, MA, LIPC, CCMHC has employed administrative assistants who manage the transcription, billing, scheduling, filing, and other miscellaneous office duties and that these individuals have been bonded to uphold the state and federal guidelines with regard to maintaining confidentiality. I understand that Scott D. Walls, MA, LIPC, CCMHC has employed Medical Billing Associates, a professional billing agency that manages his billing. Scott D. Walls, MA, LIPC, CCMHC will release the written or verbal information regarding my intake or counseling sessions only upon receipt of my written consent and only to those specified by myself, except in unusual circumstances. In circumstances where there is risk of danger and/or impending harm to myself or others, child abuse, and/or certain legal situations (for example, court subpoena of your records), Scott D. Walls, MA, LIPC, CCMHC would be mandated by law to disclose such information for my protection and/or that of others. In such situations, my counselor will make reasonable attempts to discuss the situation with me and enlist my participation in resolving the matter, if possible. If I have any questions, I understand that I can discuss them freely with Scott D. Walls, MA, LIPC, CCMHC.

 I have had these rights explained to me and by my signature; I indicate my understanding and agreement. I also understand that I have the right to refuse to sign this consent form. By my signature, I authorize that a photocopy or facsimile (FAX) copy shall have the same effect and authority as the original copy of this document.

 **Legal Guardians**: Children and adolescents may need to discuss information with their counselor in confidence. Often, such information is important for the purposes of providing your child with appropriate assessment and treatment services, but would not be provided to the parent. Scott D. Walls, MA, LIPC, CCMHC requests that you support your child’s need for privacy, excluding situations in which there is a risk to the health and welfare of your child.

Client/Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_