INFORMED CONSENT TO TREATMENT of Alliance Child & Family Solutions LLC d/b/a ACFS TEXAS

1. **Participants of Therapy:** "Client" shall refer to either the sole participant of individual counseling/therapy or to all participants in family/couples counseling/therapy together as a single unit as indicated by the signature(s) of any/all participating parties at the end of this document. If there is a request for the treatment records of family/couples counseling/therapy, the ACFS Texas staff and/or subcontractor ("Therapist") will seek the authorization of all members of the treatment unit before releasing confidential information to third parties. Also, if Client's records are subpoenaed, the Therapist will assert the psychotherapist-patient privilege on behalf of Client.

   I/we understand that during the course of treatment, the Therapist may request to see a smaller or larger part of the treatment unit (e.g., seeing only an individual participant of couples counseling/therapy or seeing a caregiver, parent or siblings in addition to the individual participant of counseling/therapy) for one or more sessions. These sessions should be seen as a part of the work that the Therapist is doing with the individual or family/couple, unless otherwise indicated. The Therapist may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit, in order to effectively serve the unit being treated. The Therapist will use his/her best judgment as to whether, when, and to what extent disclosures will be made to the treatment unit, and will also, if appropriate, give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. **Thus, if you are a participant of family/couples counseling/therapy feel it necessary to talk about matters that you absolutely want to be shared with no one, you should consult with an therapist who can treat you individually.**

2. **After-Hour Emergencies**:
   a. If you should experience a life-threatening emergency, please call 911 or go to the closest emergency room. If you have other after-hours mental health emergency, you may also contact our main number 817-851-2042 x 1 to be connected to the National Suicide Hotline.
   b. Please call during regular business hours for non-urgent questions or concerns.

3. **Consent to Evaluate/Treat:** As a participant in treatment, I/we voluntarily consent to participate in a mental health evaluation and/or treatment by the Therapist. I/we understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
   a. The benefits of the proposed treatment
   b. The risks of the proposed treatment
   c. Alternative treatment modes and services
   d. The manner in which treatment will be administered
   e. Probable consequences of not receiving treatment

   The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a licensed counselor, a licensed social worker or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Texas Law for Psychological, Social Work, Professional Counseling, or Marriage and Family Counseling.

   Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, as well as expectations regarding the length and frequency of treatment. It may be beneficial to the client, as well as the referring professional, to understand the nature and cause of any difficulties affecting daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning.

4. **Benefits to Evaluation/Treatment:** Possible benefits to treatment include improved cognitive functioning, academic or job performance, health status, quality of life, and awareness of strengths and limitations. **There are no guarantees about what will happen as treatment requires a very active effort on the part of the client.**

5. **Risks of Evaluation/Treatment:** Evaluation risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life.

6. **Alternative Treatments:** Alternative treatment methods may include the use of medications as prescribed by a licensed medical professional. Therapist may assist in recommending medical professionals who can assist in this

process, but Therapist is not able to prescribe medications under any of the licensures utilized for psychotherapy, and/or counseling/therapy.

7. **Treatment Administration:** Counseling/therapy will be administered face-to-face a maximum of once daily with the individual and/or family as is needed for maximum benefit, for the duration and frequency discussed at onset of counseling/therapy.

8. **Probable Consequences of Not Receiving Treatment:** Possible consequences of not receiving or participating fully in treatment can include impairment of work activities, family relationships, or social functioning. The Therapist will discuss specifics during the counseling/therapy as client actions are proposed.

9. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. Client will be responsible for any charges not covered by insurance, including co-payments, co-insurance, and deductibles. Fees are available upon request. Records will not be released until payment made in full.

10. **Confidentiality, Harm, and Inquiry:** Information from the evaluation and/or treatment is contained in a confidential medical record at ACFS Texas, and I consent to disclosure for use by the Therapist for the purpose of continuity of care. Per Texas mental health law, information provided will be kept confidential with the following exceptions: 1) if client is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; 3) if concerns about past impropriety or exploitation by a mental health professional; or 4) if a court order is issued to obtain records.

11. **Right to Withdraw Consent:** I/we have the right to withdraw my consent for evaluation and/or treatment of myself or my child at any time by providing a written request to the treating Therapist and/or ACFS Texas.

12. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

By my signature below, I am indicating that I have read and understand all of the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of the Therapist or Staff about the above information at any time. I also acknowledge by my signature below that:

1. I have received a copy of all of the following forms:
   a. Informed Consent to Treatment *(present form)*
   b. Privacy Policy
   c. Cancellation Policy
   d. Client Financial Responsibility
   e. Court Fees & Involvement
2. I voluntarily agree to receive mental health assessment and mental health care, treatment, and/or services, and I authorize the agency to provide such services as considered necessary and advisable,
3. I also attest that I have the right to consent to the treatment for myself or ourselves as a couple/family or of any participating minor client(s),
4. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may at any time stop such services received through the agency, and
5. I have read and understood these statements and have had ample opportunity to ask questions about, and seek clarification of anything unclear to me.

All of these signatures are signed and submitted as of today's date, _____

Printed Name of Adult Client #1	**Signature**
Printed Name of Adult Client #2	**Signature**

INFORMED CONSENT TO TREATMENT of
Alliance Child & Family Solutions LLC
d/b/a ACFS TEXAS

Printed Name of Minor Client #1	**Signature of Legal Guardian**
Printed Name of Minor Client #2	**Signature of Legal Guardian**
Printed Name of Minor Client #3	**Signature of Legal Guardian**
Printed Name of Minor Client #4	**Signature of Legal Guardian**

***NOTE: If this form is being signed electronically through DrChrono OnPatient *(via computer or iPad)* or via AdobeSign that I am consenting to all of the above statements with my electronic signature, even if the signature does not appear on the exact lines above.**

FOR PARTICIPANTS OF FAMILY/COUPLES COUNSELING/THERAPY ONLY:

As stated previously, "Client" shall refer to all participants in family/couples counseling/therapy together as a single unit as indicated by signature of all participating parties above. However, I request to be named the primary recipient of services in order to file such family/couples treatment on my insurance. I understand that this does not negate the definition of client or any other points discussed in this document providing Informed Consent to Treatment.

Printed Name of Adult Client	**Signature**

***NOTE: If this form is being signed electronically through DrChrono OnPatient *(via computer or iPad)* or via AdobeSign that I am consenting to all of the above statements with my electronic signature, even if the signature does not appear on the exact lines above.**