Consent and Service Agreement

Welcome to your first session at *Wilmington Mental Health*! It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered. Please review this form carefully and feel free to ask any question.

General Description of Psychotherapy, its Risks, and Benefits: Psychotherapy is a goal-directed relationship that is influenced by the personalities of the therapist and the patient, and the problem you are experiencing. The potential benefits of counseling are many and patients who fully engaged in the process of therapy are likely to benefit the most. These benefits include, but are not limited to, experiencing significant reduction of adverse symptoms, increased satisfaction in interpersonal relationships, greater personal awareness and insight, enhanced coping and resolution skills, and attainment of personal goals, but there are no guarantees that this will happen. Patients understand that the process of psychotherapy is difficult and often involves discussing unpleasant aspects of your life, and that you may, to some degree, experience uncomfortable or negative feelings or discomfort. Some patients have even reported feeling worse after counseling. If you are experiencing uncomfortable feelings, please let your therapist know.

Consent for treatment: I understand that I have a condition that requires diagnosis and treatment. I will have a chance to discuss with the therapist the treatment that my care team believes is needed. *Wilmington Mental Health* and its associates cannot promise specific results. To provide this care, *Wilmington Mental Health* and its associates may collect information about my health, including genetic information such as family health history.

I, _____, am requesting treatment from *Wilmington Mental Health* and its associates**.** As a condition of that treatment, I acknowledge the following items and agree to them. (Please initial each item.)

I understand that:
_____ The therapist believes the outpatient treatment strategies to be used provide a useful intervention for psychological issues and/or chemical dependence problems; however, no specific outcome can be guaranteed.

_____ Treatment participation requires some basic ground rules. These conditions are essential for a successful treatment experience. Violation of these rules can result in treatment termination.

_____ Services are provided by psychologists, licensed professional counselors, licenses social workers, licensed marriage and family counselors, master's-level counselors-in-training, or other certified addiction staff.

Consent to Videotape/Audiotape:
_____ To help ensure the high quality of services provided by the therapist, sessions may be audiotaped or videotaped for training purposes. The patient and, if applicable, the patient's family consent to observation, audiotaping, and videotaping.

Confidentiality:
_____ All information disclosed in these sessions is strictly confidential and may not be revealed to anyone outside without the written permission of the patient or the patient's family. The only exceptions are when disclosures are required or permitted by law. Those situations typically involve substantial risk of physical arm to oneself or to others or suspected abuse of children or the elderly.

Termination:
_____ Suspension, termination, or referral shall be discussed between therapist and patient. Very rarely, lack of cooperation by a patient may interfere substantially with the therapist's ability to render services effectively to the patient or to others. In situations where the patient displays lack of commitment or there is an unresolved conflict/impasse between therapist and patient, the therapist may discontinue services to the patient.

Client Follow Up: _____ We may follow up with you after counseling has ended. A 1-month, 3-month, or 6-month follow up call from your therapist may be carried to check in with you and see if gains made in counseling have been maintained. In addition, staff from Wilmington Mental Health might call you to ask for your feedback on your experience at Wilmington Mental Health. If you would prefer that we do not contact you, simply inform your therapist and your preferences will be respected.

_____ I certify that I have read, understand, and accept this Service Agreement and Consent. This agreement and consent covers the length of time I am involved in in treatment activities at this facility.
(This form must be signed by the patient (rather than another person), unless the patient lacks mental capacity to make decisions or physical capacity to sign.)

_____ _____
Patient or Authorized Representative Signature Date

Interpreter, if used: _____ Language/Organization: _____ Date: _____ Time: _____

WILMINGTON MENTAL HEALTH
Wilmington Mental Health
3955B Market St
Wilmington, NC 28411
Tel: 910-777-5575 | Fax: 910-777-5273
Email: info@wilmingtonmentalhealth.com
Website: wilmingtonmentalhealth.com