Forensic Consultation & Counseling Service, LLC

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135 Granger St. Rutland, VT 05701-4405
Office: 1-802-772-0700 Fax: 1-802-771-8009
Email: info@fccsvt.com

Client's Name: _____ Client's DOB: _____

Case Number: _____ Date of Service: _____

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that as a subscriber to Forensic Consultation & Counseling Service, LLC (FCCS), I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me the client. The goal of the assessment process is to determine the best course of treatment for me or my family. Typically, treatment is provided over the course of several weeks but is determined based upon treatment need and the needs of the client.

I understand that all information shared with the clinicians at FCCS is confidential and no information will be released without my consent. During the course of treatment at FCCS, it may be necessary for my therapist to communicate with other providers. Written authorization will be requested prior to any discussion with outside providers. I understand that my therapist will discuss the communications with me. Consent to release information is given only through written authorization and will require some forward planning. Verbal consent will not be allowed per regulations, unless the Director has approved special circumstances and was submitted via written request. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provides FCCS services. All professionals-in-training are supervised by licensed staff. I have been offered to view or receive a copy of staff licenses and resumes.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.
If I have any questions regarding this consent form or about the services offered by FCCS, I may discuss them with my therapist or the agency director. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by FCCS. I understand that I may stop services at any time; however I will be responsible for any amount owed at the time services were ended.

_____ _____
Client Signature Date Counselor's Signature Date

Revised 1/17/19