WEST BERGEN MENTAL HEALTHCARE
CONSENT FOR TREATMENT

1. I have been fully informed of my rights as a consumer of this agency, the extent and limits of confidentiality in treatment, and the goals associated with this treatment. With that knowledge, I request and consent to receive treatment from staff of this agency.
2. I understand that the staff of this agency may not disclose information about my treatment to anyone outside this agency without my written consent, except as required by law including by example but not by limitation to:
   a. Comply with a court order;
   b. Prevent suicide/self-harm or harm to others; or
   c. Stop and prevent abuse of a child, senior, or disabled person
3. I also understand that my participation in treatment may require staff of this agency to provide and/or receive information about my treatment from or to a referring agency and/or an insurance company or other payer. Where this is the case, I will be provided with the specific types of information that will be disclosed.
4. I understand that in order to coordinate my treatment, my physician, case manager, and/or counselor may need to share my information with supervisors, team members, physicians, and colleagues within West Bergen Mental Healthcare, Inc.
5. I understand that my case manager may work with me at this agency, in my home, or in other settings based on his/her professional judgment. I further understand that my treatment may involve my participation in individual, couple, family, and/or group counseling.
6. I understand that if I participate in group counseling, a condition of my doing so is that I protect the privacy and confidentiality of other participants. I agree that if I participate in group counseling, I will not disclose information about the identity, words, or actions of other group counseling participants to anyone outside the treatment group.
7. I understand that I may revoke my consent to treatment, which means terminating treatment, at any time. If I revoke said consent said revocation may be confirmed by the Agency or by me in writing.
8. I have been advised that revocation of my consent does not constitute a waiver of my confidentiality rights nor does it relieve me of my duty to protect the privacy and confidentiality of other group counseling participants.
9. If agency staff needs to contact you by phone, may they, identifying themselves from West Bergen, call you?

   ☐ Yes ☐ No

   If yes, please indicate preferred phone # to reach you: ____________________________

Client/Guardian Name: ____________________________ Signature: ________________________ Date: __/___/______

Children over age 14: Name: ________________________ Signature: ________________________ Date: __/___/______

Agency Representative Name: _______________________ Signature: ________________________ Date: __/___/______