Doris M. Dominguez, MSW, LCSW
Licensed Psychotherapist

Client Informed Consent

I have chosen to receive psychotherapy/psychodiagnostic services through Doris M. Dominguez, MSW, LCSW. My choice has been voluntary and I may terminate treatment at any time. I understand that there is no assurance that I will feel better because psychotherapy/psychodiagnostic assessment is a cooperative effort between my therapist and me. I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand confidentiality of records or information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that the confidentiality of my records may be breached under the following conditions:

1. If there is reason to believe that there is a clear and immediate probability that I will seriously harm others or myself.
2. If there is evidence or strong suspicion of child or elder abuse.
3. If a court orders the release of my records.
4. If I raise my mental status or competency in a legal proceeding.
5. If I sign a waiver requesting release of information.
6. My insurance company paying for services has the right to review all records.

I have read the basic rights of individuals participating in psychotherapeutic process. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating the receipt of services.
3. The right to humane care and protection from harm, abuses, and neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel and select practitioners of my choice at my expense.

I have read and understand this information and am consenting to my (or my dependent) receiving outpatient treatment.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Provider Signature Date