Hilltop Counseling Services
1045 Elm Street
Bowling Green, KY 42101
LeeAnn: 270-392-7727 Office/Melissa: 270-843-1804 Fax 270-843-0154

INFORMED CONSENT & LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse and/or neglect of an individual
If a client discloses that he or she has or is abusing or neglecting another individual (child, elderly, disabled person or adult), or had or is being abused or neglected by an individual, or discloses spousal domestic violence, Kentucky law requires mental health professional to report such behaviors to the appropriate state and/or local authorities.

Court order to testify
Mental Health care professionals are required by law to respond to any and all court orders. Clint's confidentially is no longer protected if a counselor/therapist is subpoenaed to testify in a court of law. However, the counselor/therapist will do everything possible to protect your confidentiality while still complying with the order. Furthermore, upon any charges filed agents a counselor/therapist your confidentiality is no longer protected.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
As clients, minor children and adolescent also deserve the right to privacy and confidentiality.
However, it is understood that as a parent you are responsible for and concerned about your child. Therefore, a verbal summary of your child's session will be provided to you upon request. This summary may include and is not limited to play themes in the case of play therapy, general concerns or issues of the child and of the counselor, and progress toward counseling goals. As part of our treatment agreement you agree not to have me called as a witness for any court appearance.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. All of our communication becomes part of the clinical record. Records are the property of Hilltop Counseling Services (HCS). Adult and minor records will be disposed of in accordance with the agency's policies.

The client is court-ordered for treatment
The client will be asked to sign releases of information forms in order for the counselor/therapist or HCS to communicate with the court, an attorney, the DOT or any other entity. A refusal to sign a release of information will deny any communication with such parties, unless under a subpoena ordered to do so.

You as the client direct me to tell someone about you
Through a signed Release of Information allowing me to give information about you the client to a specific individual. Verbal consent of release of information is only accepted when all parties are present and is limited to only that one time event. Without a signed release of information no future communication with a third party is permitted.

Family or marriage counseling
In the case of marriage and family counseling, the counselor/therapist will keep confidential (within the limits cited above) anything an individual disclose without the other family member's knowledge. However, it is encourage to keep open communication between family members and the counselor/therapist reserves the right to terminate the counseling relationship if they judge the secret to be detrimental to the therapeutic process.

Email
If you choose to use email it is with an understanding that the mental health professional, and/or the practice *cannot* fully protect your information. All Emails are sent out with disclaimer however, this does not protect from hackers, or hosting scanning. Additionally, any Email communication could be subpoenaed and used in court.

Text messaging
If you choose to use text messaging it is with an understanding that the mental health professional, and/or the practice *cannot* fully protect your information. Never is any clients contact information saved on the mental health professional phone. However, any and all information communicated through text is at risk. Additionally, phone records including text message could be subpoenaed and used in a court of law.

Facebook
A counselor/therapist will not accept any personal friend requests from clients on their personal Facebook page. This is to protect the working relationship and your confidentiality. However, you are welcome to like and follow the office's page.

Public
If a counselor/therapist sees you in public, they will protect your confidentiality by acknowledge you only if you approach them first. They will not introduce you to anyone they are with.

Hilltop Counseling Services

1045 Elm Street
Bowling Green, KY 42101
P: 270-843-1804
F: 270-843-0154

INFORMED CONSENT & LIMITS OF CONFIDENTIALITY

By your signature below, you are indicating that you read and understood this statement. Any questions you had about this statement were answered to your satisfaction and that you were furnished a copy of this statement. The signature of a representative of Hilltop Counseling Services verifies the accuracy of this statement and acknowledge the commitment to protect the privacy of all clients.

_____
Printed Name of Client (if the client is a minor, print the minor's name).

Is the client a minor (under age 18)? _____Yes _____No

If yes, please print the name of the client's custodial parent or league guarder: _____

____ (Client initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is _____.

The **email** that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in you wireless plan (contact your carrier for pricing plans and detail).

Revocation
I hereby revoke my request for future communications via email and/or text.
____I hereby revoke my request to receive any future appointment reminders feedback and general health via text messages.
____I hereby revoke my request to receive any future appointment reminders, feedback and general health via email.
NOTE: This revocation only applies to communication from this practice

Client Name:_____

Client/Client Representative Signature: _____

_____ _____
Signature of Client/Custodial parent/Legal Guardian Date

_____ _____
Signature of therapist or counselor Date