Valley|Cities

**RECEIPT OF DOCUMENTS**

By signing below, I certify that I have received:

- Valley Cities Consumer Handbook
- A clinical staff Disclosure Statement
- Valley Cities Notice of Privacy Practices
- King County Notice of Privacy Practices
- Washington State Publication What to Expect from your Licensed Counselor.
- Washington State Publication Mental Health Advance Directives, Information for Consumers (for clients 18+ and emancipated minors)

By signing below, I also acknowledge that I have read and understand my client rights.

| **Client Signature:** | **Date:** |
|---|---|
| | |

**CONFIDENTIALITY**

Generally, the information you pass on to a clinician is not discussed outside of your treatment team. Valley Cities will not disclose information that you have given unless:

- You sign a release of information authorizing us to disclose this information (parents of children twelve (12) and under are responsible for providing this permission).
- Your clinician thinks you are in danger of harming yourself or someone else.
- Your clinician has any reason to suspect a child, a developmentally disabled person, or an elderly person is being abused or neglected.
- The release of information is court ordered or otherwise legally required.
- Other reasons for release as allowed or required by law, specified in the Notice of Privacy Practices and the Washington Department of Health brochure What to Expect from your Licensed Counselor.
- Family members or friends cannot see or receive information about your records without a signed release. Your clinician cannot tell them anything without your written permission, but can listen to information they share or give them general information about mental illness and services that are available.

By signing this form, I acknowledge that I have read and acknowledge this information.

| **Client Signature:** | **Date:** |
|---|---|
| | |

**CONSENT FOR TREATMENT**

The information in this application and consent form is complete and accurate to the best of my knowledge. I give my permission to contact my Emergency Contact in the event of an emergency.

I request and authorize the staff at Valley Cities Counseling & Consultation to evaluate, treat or provide consultation to myself or to the individual named below of whom I am the parent or legally constituted guardian.

| **Client Signature:** | **Date:** |
|---|---|
| | |

**---OR---**

| **Parent/Guardian Signature:** | **Printed Name:** |
|---|---|
| | |
| **Relationship to Client:** | **Date:** |
| | |

**All voluntary clients 13 years of age and older must sign that they consent.**