Sarah Hart Wills, LICSW

Consent to Treat

The following describes the conditions under which Sarah Hart Wills, LICSW will provide treatment to: (name of client) ____________________________. The word "I" in this document refers to me in the role as
❍ client ❍ parent ❍ guardian ❍ other: ___________________________

RELEASE OF INFORMATION

I, _____________________________, understand that all information about my treatment, or that of my minor child, will be kept confidential, unless I voluntarily agree to its release to another agency or individual. Exceptions are by authority of a court order or when otherwise expressly required by law, including, but not limited to, abuse and neglect under state law, and threats to harm myself or others or my minor child's threats to hurt self or others.

I understand that mental health professionals have a duty to report suspicions of abuse and/or neglect to the appropriate state authority. They have a duty to protect me if I, or my minor child, threaten to harm myself/themselves. They have a duty to warn others if I, or my minor child, threaten to harm others. Under these circumstances, Sarah Hart Wills, LICSW may release information about my, or my minor child's, treatment without my consent.

AUTHORIZATION TO RELEASE TO INSURANCE COMPANY

I authorize my insurance company or other agents paying for my treatment to receive information regarding my mental health or substance abuse care for the purposes of quality-assurance monitoring, utilization review and payment of claim. I may revoke this consent at any time by notifying my treatment provider in writing.

COUPLES/MARITAL COUNSELING

I understand that information gathered in sessions with both persons present may later be obtained by either party and may later be released to a third party by written authority by either person.

MINOR CHILD

I understand that treatment information is available, during treatment or any time in the future, to each person who can demonstrate legal custody at the time of release. Treatment information concerning the minor child may also be released to a third party by authority of any one parent who can demonstrate legal custody at the time of release, by authority of a court order, or when otherwise expressly required by law. In the context of a divorce or custody dispute in court, the therapist will not release information about the child's treatment to either parent or to a third party without the consent of both parents.

SUSPENSION/TERMINATION OF SERVICES

I understand that failure to meet my responsibilities as a client (as outlined in Client Rights and Responsibilities) may result in suspension and/or termination of services. I understand that other causes for suspension and/or termination may apply and if so, will be reflected in writing by my therapist. I understand that my case may be closed if I have indicated that I no longer wish to receive services, or if I have not had contact with my therapist for a period of 60 days. Other special arrangements may be made on an individual basis.

STATE-FUNDED SERVICES

I understand that for those services funded by the State of New Hampshire, my records may be reviewed by staff from the New Hampshire Division of Behavioral Health to determine if I am receiving quality care.

TREATMENT TEAM

If I have a medical/psychiatric emergency, state law allows Sarah Hart Wills, LICSW to exchange information with emergency personnel. If I am hospitalized voluntarily or involuntarily for psychiatric reasons, I give consent for my therapist, Sarah Hart Wills, LICSW to exchange information about me with staff at the Mental Health Unit of Cheshire Medical Center, Monadnock Family Services Emergency Services Team, and any other designated receiving facility.

______________________	__________	______________________	__________
Client*	Date	2nd Party in Couples	Date
Parent/Authorized Person*	Date		

* This form is not valid if signed before your first session