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Casey Voichoskie, LIMHP, RPT, PC
Eryn McMaster, PhD, LLC
Alexandria Reznicek, LIMHP, LLC

CONSENT TO THERAPY AND CONFIDENTIALITY STATEMENT

My provider has explained that my participation in services is completely voluntary and confidential. Services provided at this clinic may include medication management, individual therapy, family therapy, and/or psychological assessment. The goals for my treatment will include reduction of symptoms, improvement in functioning, health and wellness, and improvement in chief complaint.

In signing this document, I provide my voluntary consent to participate in treatment for myself and/or my minor child. I understand that I may refuse and/or terminate services for myself and/or my minor child at any point, without adverse repercussions between this agency and myself.

I also understand that Encompass Care, LLC will maintain protected health information records relevant to therapy, as well as information obtained through consultation with other professionals. I understand that these records are restricted to the internal use of Encompass Care, LLC and their confidentiality will be strictly maintained at all times. I understand that Encompass Care, LLC has employed administrative assistants who manage the transcription, billing, scheduling, filing, and other miscellaneous office duties and that these individuals have been bonded to uphold the state and federal guidelines with regard to maintaining confidentiality. Encompass Care, LLC will release the written or verbal information regarding my intake or treatment sessions only upon receipt of my written consent and only to those specified by myself, except in unusual circumstances. In circumstances where there is risk of danger and/or impending harm to myself or others, child abuse, and/or certain legal situations (for example, court subpoena of your records), Encompass Care, LLC would be mandated by law to disclose such information for my protection and/or that of others. In such situations, my provider will make reasonable attempts to discuss the situation with me and enlist my participation in resolving the matter, if possible. If I have any questions, I understand that I can discuss them freely with my provider.

I have had these rights explained to me and by my signature; I indicate my understanding and agreement. I also understand that I have the right to refuse to sign this consent form. By my signature, I authorize that a photocopy or facsimile (FAX) copy shall have the same effect and authority as the original copy of this document.

Print Patient Name:____

Parent/Patient Signature:____ Date:________________

Encompass Care Representative:____ Date:_________________

Children and adolescents may need to discuss information with their provider in confidence. Often, such information is important for the purposes of providing your child with appropriate assessment and treatment services but would not be provided to the parent. Encompass Care, LLC requests that you support your child's need for privacy, excluding situations in which there is a risk to the health and welfare of your child. I provide my permission to my child's provider to maintain the confidentiality of my child (name) ___________________________, except in circumstances in which there is a risk to her/his health or welfare.

Parent Signature____

Revised 9.2022