Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Document Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of Informed Consent for Counseling and Support Services**

I/We understand and am/are in agreement with the following terms of counseling treatment obtained at Safety Forces Support Center.

**Benefits of Counseling and Support Services**

The benefits derived from counseling and/or support services may include, but not limited to the following:

Relief from distressing emotional, mental and/or relational problems,

Enhanced communication with significant persons in your life,

Improvement in physical functioning brought on by improvement in your emotional well-being,

Increased problem-solving and coping options,

Better understanding of situations/problems facing you,

Improved functioning with daily living brought about through education and training,

Resolution of problems through advocacy made on your behalf with other organizations, businesses, and individuals in the community.

**Risks Associated with Counseling and Support Services**

The risks associated with counseling and support services may include, but not limited to the following:

The possibility that your situation and/or condition will not improve or worsen should counseling and support system not be obtained,

The possibility of no improvement or worsening of your situation even if service is obtained,

The decision to obtain counseling and/or support services may not, in and of itself, resolve your problem or concern,

There may be a potential for emotional strains, stress, and life changes as a result of counseling and support services,

You understand Safety Forces Support Center will do its best to assess your progress on a session to session basis. Chronic non-improvement is treated as a reason for possible referral to another, possibly more appropriate service provider, within the community.

Your clinician may consult with their clinical supervisor or Executive Director about your case should non-improvement or problems in your counseling and/or support services be encountered.

**Behavioral Support and Management**

Safety Services Support Center practices verbal de-escalation as the only approved Behavioral Support and Management intervention intended to address crisis intervention at the counseling offices or in the community where counseling and support services are provided.

**Right to Refuse or Withdraw from Counseling and/or Support Services**

You have the right to refuse or withdraw from counseling and/or support services at any time.

Should you elect to withdraw, you will be provided with referrals to alternative services by your clinician.

**Tele-health Services:**

I understand and agree that SFSC may deliver some of my counseling services through computerized electronic systems. I understand and agreed that use of Tele-health service delivery includes, but is not limited to, risks to confidentiality, disruption in delivery of service, and difficulties with communication.

\_\_\_\_\_ I agree to accept SFSC texts at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ I agree to accept SFSC email at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing:**

SFSC Counseling is provided to First Responders and Family members, with no out-of-pocket cost to them. While some SFSC services are underwritten by grants and donations, billing insurance helps us cover counseling expenses to ensure we can continue serving those who need it.

\_\_\_\_\_ I agree to have my insurance billed by Safety Forces Support Center.

\_\_\_\_\_\_ I do not wish to have my insurance billed.

**Client’s Rights:**

\_\_\_\_\_\_ I have received and read the Safety Forces Support Center Client’s Rights brochure, which includes HIPAA and Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Couples, Partner Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature Date

Client Informed Consent for Treatment.12142020