All Things Are Possible
Community Counseling Services

CLIENT RECORD # _____

CONSENT FOR SERVICES

Client's Name: _____ DOB: _____

I, _____, hereby consent to receive therapeutic

services from All Things Are Possible Services, LLC.

I understand the benefits and risks of these services as well as the alternatives to the recommended services and/or treatment. Unless specifically stated otherwise, this consent expires upon completion of these services from **All Things Are Possible Services, LLC.** I understand that I am free to withdraw consent for services at any time. I understand that my admittance in services may be discontinued and referrals given if indicated. I agree to receive services of the type and frequency defined in my individual Treatment plan.

LIABILITY WAIVER

I hereby release and hold harmless from any liability, **All Things Are Possible Services, LLC**, including its paid and volunteer staff, members or its Board of Directors, Chief Executive Officer, and their heirs executors and administrators, and any other agents or representatives of **All Things Are Possible Services, LLC** for any claim or cause of action of any kind, including specifically, personal injury which may occur while participating in any program or activity of any kind conducted, approved, organized, or sponsored by **All Things Are Possible Services, LLC.**, or its representatives, these programs or activities including but not limited to field trips and transportation to and from said programs or activities.

_____ _____

Client or Guardian Signature **Date**

_____ _____

Clinician Signature and Title **Date**

Date Consent Expires: A Year from Date Signed

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CLIENT RECORD # _____

STATEMENT OF CLIENT RIGHTS

1. You have the right to receive treatment that will be free of discrimination by race, religion, gender, sexual orientation, ethnicity, age, martial status, Vietnam era veteran status or disability.

2. You have the right to be treated with consideration, respect, and full recognition of your individuality.

3. You have the right of protection from harm; physical, mental, & sexual abuse; harassment; and exploitation. All allegations of client abuse by staff must be reported to Yvette Bishop or the Secretary of Health and Mental Hygiene who must report them to the local law enforcement agency.

4. You have the right to treatment that will include:

    a. provision of treatment according to an individualized treatment plan;
    b. active participate in the treatment planning process;
    c. periodic review of the treatment plan and your progress toward your goals.

5. You have the right to receive an explanation of services offered, and any financial obligations prior to receipt of services.

6. You have the right to be informed of how to access assistance in an emergency.

7. You have the right to confidentiality regarding treatment, your involvement in the program and your client record; no information will be released without your (or your guardian's) consent, in writing, except by court order, or as otherwise authorized by law, or in the case of a medical emergency, or to qualified personnel for audit or program evaluation.

8. You have the right to review your client record upon request, in the presence of an assigned staff person.

_____

Signature of Client Date

_____

Clinician Signature and Title Date

All Things Are Possible
Community Counseling Services

CLIENT RECORD # _____

Emergency Contact List

Client Name: _____ DOB: _____

Guardian Name	**Address**	**Phone Numbers**
Name Contact relationship	**Address**	**Phone Numbers**
Name Contact relationship	**Address**	**Phone Numbers**
Physician name Medical Alerts	**Address**	**Phone Numbers**

I understand that in the event of an emergency, as defined by **All Things Are Possible Services, LLC**, attempts will be made to contact the persons above for purposes of notification. I authorize any treatment deemed necessary to be provided to me in the event of an emergency. It is my preference that such treatment is provided by the above physician if possible. I also give consent for **All Things Are Possible Services, LLC** to release to the above persons/provider pertinent information relevant to the emergency treatment.

Client or Guardian Signature Date

Clinician Signature and Title Date

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CLIENT RECORD # _____

CRISIS PLAN

Client Name: _____ DOB: _____

1. If client is in immediate danger of hurting him/herself someone else, ANY adult present MUST call 911 for the client to be transported to the nearest hospital for assessment.

2. If client expresses the intent to hurt him/herself or someone else, the ANY adult present should immediately call the client's therapist for further instructions. If there is no response from the therapist within 15 minutes, ANY adult present MUST call 911 for the client to be transported to the nearest hospital for assessment.

RUNAWAY behavior, the responsive adult present is to:

1. Escort client from the situation and talk with them to calm them down.
2. Ask client what he or she needs at the time.
3. DO NOT attempt to physically restrain client if they threatens to runaway; immediately call 911 and have someone else follow client until the police arrive.
4. Notify the counselor at **All Things Are Possible Services, LLC** during normal business hours.

AGGRESSIVE behavior, the responsive adult present is to:

1. Escort client from the situation and talk with them in an attempt to calm them down.
2. Speak to client in a calm voice saying that they need to stop the behavior and remind them so their behavior goals.
3. If behavior continues beyond 2 (two) minutes, leave client in the room alone, or move away a distance of 20 feet to give client space.
4. If behavior continues beyond 15 minutes, ANY adult present MUST call 911 for the client to be transported to the nearest hospital for assessment.

SUICIDAL behavior, the responsible adult present is to:

1. Call 911 IMMEDIATELY for transportation to the nearest hospital.
2. Call parent/guardian to notify them of the situation.
3. Stay with client until parent/guardian arrives.

Client or Guardian Signature Date

Clinician Signature and Title Date

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CLIENT RECORD # _____

Acknowledgment of Notice of Privacy Practice

I have received a copy of the Notice of Privacy Practice of **All Things Are Possible Services, LLC.**

_____ _____
Signature Date

_____
Print name

_____ _____
Clinician Signature and Title Date

This page will be filed in the client's chart.

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CLIENT RECORD # _____

Acknowledgement of Information Received

My signature below indicates that the following forms were reviewed and explained to me, that I have had the opportunity to ask questions regarding these forms. I have received s copy of all forms discussed.

Clients rights statement	Requested copy ☐ Yes ☐ No	Received Copy ☐ Yes ☐ No
Consent for Services	Requested copy ☐ Yes ☐ No	Received Copy ☐ Yes ☐ No
Notice of Privacy Practice	Requested copy ☐ Yes ☐ No	Received Copy ☐ Yes ☐ No

Signature of Client/Parent/Legal Guardian **Date**

Clinician Signature and Title **Date**