Center For Compassionate Care
of The Elizabeth Hospice

Informed Consent for GROUP Counseling Agreement

Fees for Services and Payment of Fees

I have been informed and accept my fee for each counseling session will be:

- ☐ $_____ for a specialized support group, payable in advance of the start of the group
- ☐ Voluntary fee for service for a drop-in support group, payable at the time of the group

and I am responsible for the payment for the specialized support group. Payment is accepted in the form of cash or check.

Group Counselors

My counselor is a trained member of the Center for Compassionate Care at The Elizabeth Hospice interdisciplinary team. If my counselor is pre-licensed, s/he is under the supervision of a licensed counselor who routinely reviews issues in supervision meetings with my counselor.

Confidentiality

When I participate in group counseling, I will hear information of a confidential nature concerning other group members. I understand the importance of confidentiality and agree to keep information and experiences shared in groups in the strictest confidence.

The information I discuss with my counselor shall remain confidential unless I authorize the release of such information. Law mandates the confidentiality of a counseling session, however there are circumstances in which my counselor may break confidentiality. Examples include, but are not limited to:

- If my counselor learns or has reasonable cause to suspect I may do serious harm to myself.
- If my counselor learns or has reasonable cause to suspect I may cause serious harm to another person or another person's property.
- If my counselor learns or has reasonable cause to suspect a person currently less than 18 years of age is being (or was) subjected to child abuse or neglect.
- If my counselor learns or has reasonable cause to suspect a person over 65 years of age or a dependent adult is being (or was, if not previously reported) subjected to abuse or neglect.
- If my counselor receives a court order for the release of confidential information.

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I understand The Elizabeth Hospice, not my counselor, is the owner of my confidential counseling records.

My signature indicates I have read this Informed Consent for Counseling Agreement in its entirety, understand my rights and responsibilities, and have discussed any questions or concerns I have regarding this agreement with my counselor.

I have read the terms stated above and understand they apply to counseling provided to me or my minor child through the Center for Compassionate Care at The Elizabeth Hospice.

In signing this form, I, _____ (print name), understand and consent to counseling for myself.

In signing this form, I, _____ (print name), understand and consent to the counseling of my minor child/ren _____ for whom I am parent or legal guardian.

_____ _____
Signature of Client/Parent or Guardian of Minor(s) Date

_____ _____
Signature of Counselor Date

_____ (_____)_____
Print Name of Emergency Contact (Area Code) Phone Number