



## PARTICIPANT ACKNOWLEDGEMENT

I, \_\_\_\_\_ (name of participant), am a participant during one or more therapy visits of a client at this clinic and as such, I agree to all of the following as conditions of my participation:

- I understand that for billing purposes, there must be one identified client, and the work done in session will be tailored to the diagnosis given to the identified client.
- I am agreeing to be a part of the counseling process and I understand that my rights as a participant differ than the rights of the identified client.
- There will be a shared treatment goal process, which the family will be active participants in creating family/couples focused goal(s).
- I understand that even though I am not the identified client, I am a vital part to the treatment process, and our therapist will consider the family unit as a primary focus in session.
- I will maintain the trust and confidentiality of all information acquired from the client and/or therapist in any session in which I participate.
- The rights I have with regards to accessing or amending any information documented in the identified client's record is limited, and clinical judgement will be utilized in these situations. Such requests may lead to authorization sought by all members of the participants in treatment, especially gaining permission from the identified client.
- I am aware that information I disclose relevant to the client may be documented in that client's record, re-stated or otherwise referred to in future sessions. Those sessions may include additional individuals who were not present or were not involved in the treatment or plan for the client's treatment at the time I originally disclosed the information.
- I am aware that Family Service, its agents and therapists cannot control the actions of the client/family participants I shared information with and therefore, cannot be held liable for the client's/family participant's actions, including the sharing of information I may view as private or confidential.

I fully understand and agree to the provisions and implications of this acknowledgement. If, at any time, I do not agree with any information contained in this acknowledgement, I will discontinue my participation. This acknowledgement remains applicable to activity and information disclosed on the date of and prior to the date of discontinuation from participation.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Identified Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

By checking this box, I hereby verify that this electronically produced signature is the actual signature of the client, parent or legal guardian who has legal authority to provide such consent.