Gina Watson, LICSW
Informed Consent and Client's Disclosure Confirmation

Client's Name: ________________________________ Date of Birth:____________________

A. I voluntarily consent to evaluation and/or treatment of the above named client by Gina Watson, LICSW. I understand that I am consenting and agreeing only to those services that Ms. Watson is qualified to provide within the scope of her training. I acknowledge that no guarantees are being made to me as the result of the treatment. I also understand that Ms. Watson is an independent contractor.

B. I acknowledge that no guarantees have been made to me as to the result of the treatment or evaluation.

C. I understand that Ms. Watson may consult with other clinicians for the purposes of professional development and coverage and that such consultations are also bound by the rules of confidentiality. I understand that Ms. Watson may discuss my child's care in peer supervision and provide information to a covering clinician to facilitate continuity of care.

D. I authorize Ms. Watson to communicate with my insurance company for care authorization and care coordination upon request from the insurance company.

E. I understand that treatment is confidential with exceptions. These exceptions include, but are not limited to: disclosure to insurance companies and managed care companies for reimbursement purposes; disclosures required by law, such as suspicion of abuse or neglect of children, disabled or elderly individuals, risk of imminent hard, or duty to warn; and disclosure to other health care professionals to facilitate my child's care and treatment or as described above. I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

F. I have been given the professional qualification and experiences of Gina Watson, LICSW, her professional policies, a listing of actions that constitutes unprofessional conduct according to Vermont statutes, and the methods for making a consumer inquiry or filing a complaint with the Office of Professional Regulation.

G. In addition, I have received and been informed of client privacy rights as outlined under HIPPA. These rights include:

a. The right to be informed of the various steps and activities involved in receiving services.
b. The right to confidentiality under federal and state laws related to the receipt of services.
c. The right to humane care and protection from harm, abuse and neglect.
d. The right to make an informed decision about whether to accept or refuse treatment.
e. The right to contact and consult with counsel and select practitioners of my choice at my expense.

H. I understand that I may revoke this consent at any time except to the extent that treatment as already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will automatically expire one year after all claims for treatment have been paid as provided in the benefit plan.

I. I understand that Gina Watson, LICSW will be using the Essex Pediatric Medical Record for all documentation of treatment. I understand that this means all therapy notes are contained in the medical record and can be reviewed by medical staff.

J. I authorize the Executor/Secondary Executor to access records in accordance with Gina Watson's Professional Will.

K. I have read this document and understand and consent with the content.

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Patient Signature Date

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Parent or Guardian Signature (if under 18) Date

I certify that I am the child's legal guardian or custodial parent and am legally authorized to initiate and consent for treatment on behalf of this individual.

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Gina Watson, LICSW Date