

# Family Counseling Connection

1021 QUARRIER STREET, SUITE 414  
CHARLESTON, WEST VIRGINIA 25301

NAME: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_  
CASE NO: \_\_\_\_\_

## CLIENTS RIGHTS / CONSENT FORM

I hereby give my consent for evaluation and treatment by the staff of Family Counseling Connection., 1021 Quarrier Street, Suite 414, Charleston, West Virginia. I understand that I have the right to participate in the development of my individual treatment plan and that I may discontinue treatment at any time unless specifically mandated to participate.

I understand that, as a client of the above-named agency, I have a right to know:

- (a) The person(s) providing treatment at this agency is qualified, well trained professionals using acknowledged and accepted modes of counseling. I will not be included in research without my prior written consent;
- (b) All records pertaining to my visits to the agency are completely confidential and no information will be given to anyone, in the absence of a court order, without my express, written consent with knowledge of the purpose and intent explained fully; and
- (c) There will be no tape-recording or videotaping conducted without my written my written consent and knowledge of the purpose and intent explained fully.

I also understand that if I believe any of the above-named rights have been violated I may discuss this with my counselor. If I am not satisfied with the results, I may initiate grievance proceedings by consulting with the counselor's supervisor.

I have read, understood and received a copy of the Statement of Client's Rights and discussed any questions arising from it, with my counselor.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### **IF THE CLIENT IS A MINOR (under the age of 18) CONSENT OF A PARENT OR LEGAL GUARDIAN IS REQUIRED.**

\_\_\_\_\_  
Signature of Parent /Legal Guardian

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date