Marjane Vitaletti LPC

Licensed Professional Counselor, MA Special Education

Professional Disclosure Statement and Informed Consent

The Purpose of Counseling

The purpose of counseling is to help individuals and families resolve issues that might be interfering with the enjoyment of the process of life. You may be searching for self discovery or looking to manage a difficult life crisis. We will initially determine your goals and assess if we can work together to meet them. As counseling continues, we will regularly evaluate our progress to determine if your goals have been met r if there is a need for additional sessions, termination, or a referral to another practitioner for counseling or assistance.

My Responsibility as Your Counselor/Privacy and Confidentiality

As a Licensed Professional Counselor, I follow the Code of Ethics and Standards of Practice of the American Counseling Association and the National Board for Certified Counselors as approved by the New Jersey Professional Counselor Examiners Committee.

I must keep all information that I obtain from out counseling relationship in confidence unless I have your written permission to inform or consult with another person or agency. There are three major exceptions to this code of confidentiality.

1. I must disclose information to a third party if I learn of any potential abuse or neglect to a child or elderly person, or if I learn that you are a threat or danger to yourself or any other person.
2. If I receive information confirming that you have a disease know to be communicable and fatal, I must disclose this to a third party who by his/her relationship with you is at high risk for contracting the disease. Before making this disclosure, I must determine that you have not already informed the third party and that you have no intention to do so. I have a duty to protect you and others from harm.
3. If I am subpoenaed to release confidential information without your permission, I will inform you before discharging any information and involve you in the decision making process. If I am required to disclose confidential information without your permission, I will do my best to limit it to only that which is essential.

Should you request that I reveal information about our counseling relationship to others, you must first sign a release of information specifying the person and/or agency to be contacted and the extent of the information you wished revealed. This may include managed care or third-party payers.

Minor children also have the right to privacy, even from his/her parents or legal guardian. I will respect the privacy of any minor child unless I believe that child to be a danger to him/herself or others, or the child gives me permission to involve his/her parents or guardian in the treatment. In cases where I feel it is important for parents to be involved I will make every effort to obtain such permission.

Our Mutual Rights and Responsibilities

You have the right to ask me to explain my reasons for using certain procedures or making recommendations for your treatment.

You have the right to refuse to follow my recommendations, and/or to terminate counseling at any time for any reason.

Barring emergencies you have the right to expect that I will be available for your counseling sessions at the scheduled time.

Barring emergencies, I have the right to expect that you will arrive to counseling sessions at the scheduled time.

Barring emergencies, if you cannot make a scheduled counseling session, notice of cancellation will be made 24 hours before the scheduled session.

Records

All records are kept in a secure location. Your record will be kept securely for a period of at least 7 years after your last visit.

You have a right to see your record, but I have the right to limit that access if I believe there is compelling evidence that seeing parts of your record could cause you harm.

I have read and agree with the above (signature of client)

____ ***Date***____________

Signature of parent or legal guardian of minor child (under 18)

____ ***Date***_______________

Signature of provider__________________________________ ***Date***_______________