WESTMINSTER COUNSELING CENTER
GUARANTEE OF ACCOUNT
AND STATEMENT OF CONFIDENTIALITY

Client's name ____

A. In consideration of Westminster Counseling Center rendering services, including care and treatment to the above named client, I guarantee payment of all charges incurred or to be incurred.

B. I understand that fees are to be paid at the time of service unless otherwise agreed to by Westminster Counseling Center.

CONFIDENTIALITY

C. Furthermore, I understand that all communication between my counselor and myself will be confidential except upon signed permission of the client or as specified below:

1) Westminster Counseling Center requires certain information from the official client record for data processing.

2) Westminster Counseling Center may require certain information from the official client record for assurance of quality care, licensing standards, and research.

3) Records may be removed from Westminster Counseling Center's jurisdiction and safekeeping only in accordance with a court order, subpoena, or stature

4) Confidentiality may be broken by a counselor when said counselor has reason to believe that the client may harm him/herself or others.

5) Counselors may share information of the purpose of supervision and/or consultation without revealing my name or identity.

6) Requests for information from an insurance company will be provided as the counselor deems appropriate. I understand that it is my responsibility to let the counselor know if I do not want information shared with health insurance providers.

No other information using my name will be shared without my signing a RELEASE OF INFORMATION agreement.

I have read, and I agree to Statements A, B, and C above:

Date: ________________________ Client: ____

Date: ________________________ Guarantor: ____
(If other than client)