Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

RIGHTS & CONSENT TO TREATMENT

- You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- You have the right to be treated in accordance with professional and ethical standards of conduct.
- You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Personal Health Information (PHI) will be maintained in a secure, locked environment. Electronic records are maintained with a secure, dual firewall system called InSync. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. We will not sell your information to anyone for any reason.
- I understand that if Chrysalis shares any information, we will adhere to the "minimum necessary" rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- You have the right to discontinue services at any time. However, it is expected that you will confer with your clinician(s) rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- I understand that sessions typically run for 38-52 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjustedaccordingly.
- I consent to take part in treatment with my clinician(s). I understand that it is in my best interest to actively participate intreatment and follow treatment recommendations.
- I understand and give my consent to the use of Blueprint, a HIPAA-compliant web and mobile platform that helps me and my provider measure progress throughout treatment and make adjustments to treatment as needed.
- I understand and consent to the use of Recovery Record Service, a HIPAA-compliant web and mobile platform for eating disorder education and management to record and evaluate recovery goals and progress.
- I understand that there is no guarantee that any particular outcome will result from treatment.
- I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order toprovide me with the most effective, ethical treatment possible. The clinicians and dietitians actively collaborate and consult about mutual cases, as well as share clinical notes.
- I understand that my clinician may consult and share clinical information with their supervisor and/or clinical board and/or university in order to provide legal and ethical treatment. They may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Chrysalis Center.
- I understand that all communications with Chrysalis staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician(s). I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cell phones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although Chrysalis-based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the administrative manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws.Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Signature_____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature_____ **Date** _____