

The Attachment and Trauma Center of Nebraska  
12822 Augusta Ave, Omaha, NE 68144

**Confidentiality Clarification & Consent to Treat**

It is important that you fully understand the nature of confidentiality in the context of your relationship with The Attachment and Trauma Center of Nebraska (ATCN). The ATCN, its therapists, partners, interns, and employees will keep confidential any information disclosed by you in the course of our relationship and this information will not be disclosed to other parties without a written release signed by you. There may be exceptions however, and it is important that you are aware of the exceptions to this policy:

1. **Disclosure of Child Abuse, Endangerment and/or Neglect** – If the client discloses information that a child is being abused, endangered or neglected, the ATCN therapists, interns and employees, are required by law to report this information to the Child Protective Services.
2. **Duty to Warn** – If the counselor believes that a client poses a threat to themselves or others, the counselor is ethically bound to disclose this information to the appropriate person or agency.
3. **Court Subpoena of Records** – It is within the power of the Court system to subpoena client records from a therapist or agency.
4. Any **insurance company** covering a client’s mental health treatment will have access to any information necessary for the completion of insurance forms or the determination of benefits payable.
5. All cases may be reviewed during **Team Consultation**. Treatment is provided with the understanding that case review may be brought to the team for discussion.
6. **Exchange of information** with psychiatrists, therapists, CPS case managers, probation officers, or any other person outside the ATCN regarding the client’s case with express written permission by the client (See Consent to Release information Form).
7. **Research participation**. If asked and you agree to participate in therapeutic outcomes research, express written permission which defines the project will be obtained.

If you have any questions regarding confidentiality, please don’t hesitate to ask. Your therapist will provide you with a copy of this clarification sheet if requested.

I have read, understand, and agree to the above limitations of confidentiality.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**INFORMED CONSENT:** We ask that clients sign the following general Consent to Treatment. The client may at any time decline specific recommendations during the therapy process.

**I give my consent for services with The Attachment and Trauma Center of Nebraska to include evaluation, therapy, education, testing (if indicated) and involvement in the treatment planning process.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date