ALL INCLUSIVE COUNSELING, INC.
5540 N ACADEMY BLVD SUITE 210
COLORADO SPRINGS CO 80918
PHONE: 719-632-5033
FAX: 719-264-7697

ADDITIONAL PARTICIPANT DISCLOSURE FORM

1. As you know, I am providing services to a client, _____, who has authorized me to share information with you and to obtain information from you. You are a "collateral" or additional participant, in the treatment process.

2. You are **not** my client, and you will not be receiving treatment or services from me.

3. If you would like to receive counseling from a mental health professional, please let me know, and I will refer you to a therapist.

4. Any treatment information which I share with you is confidential. You may not share that information with anyone else.

5. Any information that you share with me will be confidential, as part of my client's treatment record, and I may share that information with my client.

I have read, understand and agree to the terms of the disclosure statement for the above named client and understand that reading it doesn't make me a client.

Additional Participant Signature: _____ Date: _____

Print Name: _____