HOPE In Home Counseling, LLC

www.hopeinhomecounseling.com

727-612-3343

Below is information regarding our therapeutic relationship and consent to treatment. By signing your initials next to each numbered item, you are indicating that you have read and understand all documents and information reviewed with you upon intake.

_____1. CONFIDENTIALITY: I have read and signed the **NOTICE OF PRIVACY PRACTICES**. I understand that all information obtained during our relationship is fully confidential. I understand that my signature is required as consent to release part or all the information. Exceptions to this include instances when 1) the client is a clear danger to themselves or others and/or 2) that client is a minor and either reports, or it is suspected that he/she has been a victim of others by physical or sexual abuse or neglect.

_____2. TELEPHONE CALLS/ TEXT MESSAGES: I will answer telephone calls and text messages Monday -Friday 9:00 a.m. to 5:00 p.m. If you contact me outside of those hours, I will contact you the next business day.

_____3. EMERGENCIES: In the event of an emergency, please contact 911/988 or go to your nearest emergency room. You may also contact the Suicide Hotline- 1800-273-8255 24 hours a day every day if necessary.

_____4. TEXT MESSAGES: Is it ok to leave text messages regarding appointments only? Do not text any confidential information. Text messages are not confidential.

_____5. EMAIL: If you email me, I will respond to the email within 24hrs. My email is confidential. Kathleen@hopeinhomecounseling.com

_____6. LENGTH OF SESSION: Sessions will last between 50-60 minutes. If you want a longer session, there will be a charge of $10 for every 15 min. If I go longer than time, you will not be responsible for the extra fee.

_____7. FEES AND PAYMENT: You are responsible for payment at the time of each session. No further appointments will be honored if you fail to make payment at the end of the session.

_____8. TERMINATION: The ending of a therapeutic relationship is an important process and should be discussed. If I have not heard from you in 90 days, unless planned I will send you a discharge letter. However, at any time you may call to reestablish therapy.

_____9. RECORDS: Your record will be kept for seven years after discharge based on State's guidelines. After that time, the record will be shredded.

I have read and understand the above. I have been given a copy of this document.

Print Name_____

Signature_____ Date_____