Informed Consent

Hello! My name is Jennifer Vezdos, and I provide professional, Christ-centered counseling in the Cincinnati area. I am excited that you have decided to take this big step toward growth and healing, and I look forward to working with you further! Although I do not discriminate in any way if you are not a Christian, I want you to feel comfortable with the type of counseling that I do perform.

The purpose of this information packet is to let you know about my counseling practice and to inform you of all the policies you need to know prior to our first session. To ensure that you have read, understood, and agree to these policies, your signature is required.

MY TRAINING & COUNSELING PHILOSOPHY

I received my Masters in Counseling from Cincinnati Christian University, and I am a Licensed Professional Counselor in the state of Ohio. My theory of who we are as people created in the image of God and how change occurs is grounded and guided by Biblical truth, yet is also clinically and psychologically informed. I seek to integrate psychology with Biblical truth to develop a rich, comprehensive understanding of how we are mental, emotional, physical, and spiritual beings. One of the main ways that Christian Counseling differs from secular counseling is that we are able to explore how a counselee's issues are playing out on both a horizontal *(with self and others)* and vertical *(with God)* dimension, and how there is powerful hope in the gospel for the specific struggles we face. In addition, I believe one of the primary goals of counseling is to come alongside of the counselee in their current struggles to help them better understand the issue(s) they are experiencing through identifying ineffective coping skills, false beliefs and other underlying factors. I believe that healing can best occur in the context of a safe, accepting environment where you can honestly share and process what you are going through.

With all of this said, I will always respect the beliefs and values of all counselees and you can determine if or how much you want to incorporate your faith, if any, into the counseling process. However, it is important for you to evaluate my counseling philosophy and assess beforehand if you think I will be a good fit for you and your needs. If you have further questions I am happy to discuss them.

COUNSELING SESSIONS

Counseling sessions are 50 minutes in duration. I will make every effort to begin and end sessions on time, so please make sure to arrive on time as well. I understand issues come up that can cause you to be late. However, please understand that we will still need to end at the scheduled end time to respect the time of the next client, and it will still be considered a full counseling session for payment, although your insurance company may not reimburse me or you if the session does not meet minimum time requirements and you will be responsible for the full payment in those situations. When you arrive at the office, please take a seat in the waiting area and I will come out to get you at our scheduled time.

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RISKS/BENEFITS OF COUNSELING

It is important for all clients to consider the benefits and risks of counseling before beginning. For example, there is a risk that you will periodically experience uncomfortable levels of sadness, guilt, shame, anxiety, frustration, loneliness, helplessness, or other negative feelings. You may recall unpleasant memories that may be disruptive for you at work, school, or home. Sometimes problems may temporarily worsen after counseling begins. Most of these risks are to be expected when making important changes in life and as different issues, thoughts, and beliefs come to the surface. Although there are no guarantees that counseling will be successful, it is important to know that the benefits of counseling have been demonstrated in hundreds of well-designed research studies.

PAYMENT

My fee for a 50-minute counseling session is $95. Clients are responsible for full payment of the session at the beginning of the appointment, unless agreed upon in advance. I do not take insurance, and I am not currently an out-of-network provider.

If financial aid is needed, special arrangements can be made on an as-need basis. If that is the case for you and you are a member of a local church, keep in mind that your church might be willing to cover a portion of your session fees so I would recommend checking with your church leadership. In the event that reimbursement by your church is offered, a release of information regarding appointment times will be required.

COURT/ATTORNEY FEES

I do not provide counseling services that are recommended by a court. If a referral is needed, I will provide you with appropriate referrals. I will not provide expert testimony in any cases, except to act as a fact witness and to provide a diagnosis, including but not limited to becoming involved in child custody and visitation recommendations, which I will not do. In the event that I am subpoenaed or otherwise involved in proceedings regarding treatment provided to you, you agree to pay for my time at a rate of $300 per hour, in addition to other costs and expenses associated with the subpoena or proceedings. You agree to pay for all time spent in connection with the legal proceeding, including preparation time, travel time, time sitting outside a courtroom and time discussing the case with my attorney. By signing this form you accept the above limitation and are willing to pay the fees associated with legal proceedings.

APPOINTMENT RESCHEDULES/CANCELLATIONS

If you cannot keep your appointment, leave me a voicemail at (513) 575-8852 anytime with at least a 24 hour notice to avoid the full appointment charge. If a 24-hour advanced notice is NOT provided, you agree to be pay the full rate of $95. Late cancellation and no-shows will need to be paid in full at the beginning of the next appointment.

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EMERGENCIES

In case of a psychiatric emergency, please go to the nearest hospital emergency room, or call Mobile Crisis at (513) 584-8577. If it is a child in a psychiatric emergency, go to Children's Hospital Emergency room at 333 Burnet Ave (513) 636-4293. If talking to a trained professional would be helpful, call (513) 281-CARE. These resources are available 24 hours a day, seven days a week, including holidays. I do not provide crisis intervention.

CONFIDENTIALITY

You understand that all information you disclose to your therapist is protected from disclosure and held in the strictest confidence and may not be released without your written consent EXCEPT AS REQUIRED OR ALLOWED BY LAW. Some exceptions to confidentiality include but are not necessarily limited to, situations where there is:

- A danger to you or another person, which requires me to provide protection to you and/ or the other person(s).
- Actual or suspected abuse or neglect of children/ minors, developmentally disabled individuals, and/or the elderly *(I am mandated or allowed by law to disclose this information to the proper authorities).*
- If a felony has been or is being committed, I am allowed to report it to the authorities.
- Presentation of a valid court order.
- Written authorization to release information signed by your or an authorized personal representative.

All documents will be stored in a secure location. Your HIPAA Notice of Privacy Practices form provides you with more detailed information on Confidentiality.

I may need to discuss your situation with colleagues from time to time and you agree that I may do that. If I do that I will only release the information necessary in order for me to provide help to you, the client.

You agree that I may release information to the Ohio Department of Commerce, which requires certain reporting of unclaimed funds. In those instances, only the minimal, required, information will be supplied.

You agree that from time to time I may have the need to consult with my practice attorney regarding legal issues involving your care *(this is an infrequent occurrence, but does happen from time to time).* My practice attorney is bound by confidentiality rules also. In addition, I will reveal only the information that I need to reveal to receive appropriate legal advice in connection with those contacts.

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INCAPACITY OR DEATH OF THERAPIST

In the event that I am incapacitated or die, it will be necessary for another therapist to take possession of your file and records. By signing this form you consent to allow another licensed mental health professional whom I designate to take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice. In signing this form below you agree that you will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional if you choose that option.

EMAIL AND TEXTING

I do not like to use e-mail or texting for communications. If you decide you want to utilize either form of communication you acknowledge that there are confidentiality risks inherent in such communications and you accept those risks. If you wish to use texting or e-mail for communications, please place your initials in the space provided: _____ *(By initializing this section you agree that you understand the risks involved in texting and e-mailing and agree to accept such risks in communications from either me to you or you to me that involve scheduling and/or therapy.)*

SIGNATURES

Your signature below serves as acknowledgment and agreement to all of the above policies, responsibilities, and limits of confidentiality.

Client Name	**Client Birth Date**	**Current Date**

Client Signature	**Date** (MM/DD/YYYY)
Parent/Guardian Signature (If applicable.)	**Date** (MM/DD/YYYY)
Counselor Signature	**Date** (MM/DD/YYYY)
Clinical Supervisor Signature	**Date** (MM/DD/YYYY)

PERMISSION TO TREAT A MINOR

As a Parent or Guardian of the client, I give permission to Jennifer Vezdos, L.P.C. to provide mental health counseling services to the client.

Client Name	**Client Birth Date**	**Current Date**

Parent/Guardian Name	**Parent/Guardian Signature**