**Informed Consent for Counseling**

1. **Counseling** is a collaborative process between the client and the counselor. There is no guarantee of the effectiveness of treatment. However, it is necessary for the client to take an active part in the process, by committing to attending counseling sessions and working toward their goals in and out of session. If a pattern of missing sessions occurs, the issue will be discussed so that options can be formulated.
2. **Appointments:** Individual therapy sessions are scheduled for 45-50 minutes, a "clinical hour". Please notify me **24 hours in advance** **by phone if you cannot keep your scheduled appointment in order to avoid being charged a no-show fee of $25.** This rule does not apply when there is an emergency situation.
3. **Risks:** In counseling, major life decisions are sometimes made including decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of the counseling experience as a result of an individual calling into question many of their beliefs and behaviors. Furthermore, symptoms may be intensified and the emotional experience may be too intense to deal with at this time. I will be available to discuss any of your assumptions or possible negative side effects in our work together.
4. **Electronic Transmissions/Internet sites/Cell Phones:** I cannot ensure the confidentiality of any form of communication through electronic media, computer, phone, text, or other technology that may be used for communication. Be advised that any communication sent to me via a computer in a workplace environment is legally accessible by an employer. I do not friend clients on Facebook or on other personal internet sites. This office number is a cellular number. I make the effort to be confidential in our conversations but cellular phones cannot be a guaranteed secure means of communication. In the case of electronic or cell phone communication, I cannot guarantee confidentiality. I do not provide emergency assistance. Please be advised to use 911 in an emergency.
5. **Records**: I am required by law to maintain records of each time we meet or talk on the phone. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply. I can be called to testify about the contents of the records and I must comply. In addition, in order to file for insurance reimbursement, I have to assign you a diagnosis. If you have any questions about this, please let me know. I will certainly share any information with you that I provide to an insurance provider.
6. **Consultation**:Information about you may be discussed in confidence, without revealing your identity, with another counseling professional for the purpose of consultation and providing you the best possible service.
7. **Fees and Payment** (other than insurance filing) will be collected at the time of service.
8. **Emergencies:** Due to being a minimal practice and being the only clinician, I may not be available for a crisis call. If there is an emergency situation for which you feel immediate attention is necessary, please contact emergency services (911) immediately or go to your nearest hospital emergency room. Available crisis line number: 1-800-432-2159. I will follow those emergency services with standard counseling.
9. **Limits of confidentiality:** the law protects the privacy of all communications between counselor and client EXCEPT in the following situations: 1) If there is suspected abuse or neglect of a child under the age of 18, or if the child disclosed abuse or neglect directly to us. I am required by law to report to authorities/CYFD. 2) If it is suspected a client presents a substantial risk or harm to another person or to him/herself. I am required by law to take protective action-which may include notifying the potential victim, contacting the police or seeking hospitalization for the client. 3) If you are involved in a court proceeding and I am ordered by the court to disclose information, I am required by law to do so. I do not participate or testify in divorce court or child custody proceedings.
10. **HIPPA/Notice of Privacy Practice/Client rights:** I am providing you with these notices, which describes how medical/mental health information about you may be used and disclosed and how you can get access to this information. By signing this page you consent for Be Well Counseling Services to disclose your health information for the purposed of providing services, treatment, and collecting payment and conducting health care operations for quality of care. The client rights page summarizes your rights as a client.
11. **I have read, understood, agree, and consent to the above conditions of service stated. I have also received the notice of privacy practices-HIPAA and client rights on this date and have had the opportunity to ask questions about and understand these policies. I hereby seek and consent to take part in treatment with the therapist named below. I am aware I may stop treatment at any time.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client Signature Printed Name Date

(\*\*For Minors only) I hereby grant permission to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to counsel/assess my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Printed Name Date

**I have discussed the issues above with the client and/or the parent/guardian of the client. My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Therapist Printed Name Date: