(INITIALS)
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Informed Consent for Receipt of Psychological Services (Adult)

This form is to document that I,_____ give voluntary permission and consent to receiving counseling services from Holly Maddy, LLC.

_____ **Purpose and Background:**
The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. Where appropriate I have also received information about the techniques and methods of treatment used by my therapist as well as any diagnosis. I understand that my therapist is licensed in the state of KY to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise.

While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Holly Maddy, LLC. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

_____ **Confidentiality:**
I understand that my conversations with my therapist will almost always be confidential. Other reasons that information may not be kept confidential include (but are not limited to)
Exceptions to Confidentiality:
1. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities.
2. I understand s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else's safety.
3. If a court of law issues a subpoena and information is required to be released by law.
4. Cases are also reviewed during Peer Review and in Clinical Supervision.
5. Also, as explained in greater detail on the "Consent to Billing" form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

_____ **HIPAA**
I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of Holly Maddy, LLC "Notice of Privacy Practices", that were effective of as their start of business on April 21, 2008. I acknowledge I was offered this policy statement on the date indicated by my signature below.

_____ **Attendance:**
I understand that regular attendance, a willingness to be open and honest and follow-through on treatment suggestions will produce maximum benefits, but that the final decision on what to do is always up to me. In addition, I understand that I am free to discontinue treatment at any time. A termination session may be requested in order to provide for any continuing areas of concern.
I understand that if I need to cancel an appointment, I will need to call 24 hours in advance. Any appointment not properly canceled will be considered a "No Show" and will be billed to me at the rate of $75 per missed appointment. Further, I understand that my insurance will not cover these charges in any way, and I will be liable for all charges that result from a missed appointment without sufficient (24 hour) notice.

_____ **Contact Information:**
The office address for Holly Maddy, LLC is: 328 Thomas More Parkway #102, Crestview Hills, KY 41017. I understand that for routine appointments and information I may call (859) 431-6333. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible by my therapist (1 business day). If I have an after-hours crisis or need assistance more quickly I can call (513) 281-CARE, or 911 If I feel I need immediate psychiatric admission to a hospital for stabilization. I understand that I may be referred to the nearest hospital emergency room if I am unable to contract for safety.

_____ **Complaints Procedure:**
If I am dissatisfied with any aspect of the services I receive, I understand that I can and am encouraged to raise my concerns with my therapist immediately. Dissatisfactions will make working together slower and more difficult if not resolved. If I feel that I have been treated unfairly or unethically and cannot resolve this problem directly, a complaint procedure is available through the KY Board of Social Work/ KY Board of Licensure for Marriage and Family Therapist PO Box 1360, Frankfort, KY 40602. Kentucky Board of Licensed Professional Counselors | 911 Leawood Drive | Frankfort, KY 40601

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment.
I release and hold harmless Holly Maddy, LLC, and its staff and agents from any action or liability arising out of my participation in treatment.

Signature of Client	Date
Signature of Witness	Date