All States - Informed Consent

My name is Maurvet Minto, LPC.

As your mental health care provider, it is my obligation to provide you with the information you need in order to decide whether to consent to the treatment that I have recommended. The purpose of this form is to verify that you have received this information and give consent to treatment. I hold the following credentials:

LPC. Please read this form carefully before signing.

Therapy is a process where mental health distresses and disorders are assessed, evaluated, and treated. There are a variety of techniques that can be used to provide relief and/or treat the mental health issues that have led you to seek therapy. These techniques and the therapy process have both benefits and risks. During our sessions, we will discuss the nature of your mental health concerns, the goals of treatment, and any treatments I recommend. This discussion will also include the potential benefits, risks, or side effects of any recommended treatment. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events in your life. Potential benefits include a significant reduction in feelings of distress, better relationships, better problem-solving and coping skills, and a resolution of specific problems. Given the nature of therapy, it is difficult to predict what exactly will happen, but I will use my best efforts to address the risks and benefits. We will discuss the likelihood of achieving our treatment goals and reasonable alternatives, and you will be actively involved in your therapy journey. You fully acknowledge that any benefit from therapy is directly dependent upon your participation and my progression through therapy. However, no guarantees can be made regarding outcomes. At any time, you may refuse a recommended treatment, or revoke your consent to the treatment altogether.

Our relationship is, and will always remain, professional. We will always treat each other with respect. You acknowledge that you have received information about me, including my qualifications and credentials, and that you may ask about my qualifications and credentials either during our sessions or by contacting Rippoy Healing. If, at any time, you have concerns or complaints about your treatment, you may direct them to me or Rippoy Healing.

Our interactions will be confidential. There may be situations, however, where I am required by law to disclose certain information to certain parties, such as state agencies or law enforcement agencies. For example, I may be required by law to report abuse or neglect of a child. Further, in the event that you are a danger to yourself or others, I may be required by law to take action to protect you and those around you,

which may result in you being hospitalized. I may also have a duty to warn anyone who may be in imminent danger as a result of your threats or frame of mind. Please ask me or Rippoy Healing if you have any questions about mandatory reporting situations.

Additionally, I respect your privacy with regard to abortion care and reproductive care and will endeavor to protect your privacy regarding the same to the fullest extent possible. I encourage you to use discretion when disclosing specific and identifiable information about other providers to me as it relates to these services.

Your records will be stored securely for a minimum of seven years. Should you ever need access to your records, please contact Rippoy Healing. You acknowledge that you have received Rippoy Healing Notice of Privacy Practices, which outlines our record-keeping and confidentiality procedures.

You have received information on the fees that I charge for my services. You understand that you are financially responsible for charges that are not covered or paid by your insurance and that there is no guarantee of reimbursement or payment by an insurance company or other payor. You hereby consent to the release of information to third-party payors or their representatives as deemed necessary by Rippoy Healing to determine benefits entitlement and to process payment claims for services provided.

You authorize and direct that payment of any health insurance or healthcare benefits otherwise payable to you for healthcare services will be paid directly to Rippoy Healing for the charges for which Rippoy Healing is authorized to bill in connection with the services provided to you. You certify that the information given by you in applying for payment is correct. You acknowledge full responsibility for and agree to pay, all charges not otherwise paid by your insurance company or other payor. Charges are due and payable upon receipt of the bill.

If you have questions, you are encouraged and expected to ask them before you sign this form. Your signature on this form indicates that you have read and understand this document and that you have had the opportunity to ask questions about anything in this form. By signing below, you authorize and consent to the performance of the treatment.

Client Name: {{client\_name}} Client Date of Birth: {{client\_dob}}

Typed Signature: {{typed-signature}}

If signed by someone other than the patient, indicate relationship: {{if-signed-by-someone- other-than-patient-indicate-relationship}}