SERVICES CONSENT

I understand that:

* I will be receiving counseling services from Susan Posada, PhD, licensed mental health counselor, licensed marriage and family therapist and NBCCH practicing at 110 W Country Club, Tampa, FL, (813)215-5558.
* I understand that my counselor cannot tell what to do or solve my problems, but rather will provide objective feedback to facilitate change, and that my progress is largely dependent on my openness to change and willingness to work outside of the session(s). (Research estimates this dependency at 40%.)
* Different counseling techniques may be utilized during the course of my treatment. Unless otherwise noted in writing, I hereby consent to the use of any counseling techniques utilized by my counselor during the course of my treatment.
* I understand that I can terminate therapy at any time, but am encouraged to have a final termination session so that my counselor can help me prevent relapse.
* I understand that my counselor is under an ethical duty to terminate when the counselor determines that I am not sufficiently benefiting from therapy and the counselor believes that I need a different level or kind of care.
* I will not make audio/video recordings of my sessions without my therapist’s permission.
* All information pertaining to my counseling experience, including the knowledge that I am being seen for counseling is strictly confidential. By law, information cannot be released in spoken or written form by my counselor without my signed consent, **with the following exceptions:**
1. There is clear and serious indication of doing self-harm.
2. There is clear and serious indication of danger to someone else.
3. My counselor receives a subpoena of which I have been properly notified and have failed to inform her that I am opposing the subpoena or court order.
4. There is indication that a child, person with a disability, or elderly person has been abused, exploited, or neglected.
5. When clinical information is required for consultation. (No identifying information will be released.)
6. My account is in delinquent status. Appropriate billing and financial information will be released to a collection agency. No clinical data will be released.)
7. I send my primary counselor an email containing private information. Please see the *Online Consent* form for more information
8. My counselor is also a professor and professional writer and occasionally uses case studies as a method to educate others. As per section G.5.a of the ACA Code of Ethics, the information will be sufficiently modified in order to obscure identity.
9. If I am using insurance, I give this office permission to release any information obtained during treatment that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.
10. If the mode of treatment is couples therapy, I give my therapist permission to utilize information obtained in individual sessions for treatment purposes.
* A 30-day period without an appointment constitutes termination of the therapy relationship. Therapy may be assumed at any time upon agreement of all parties.
* If the mode of treatment is couples therapy, and I decide to stop attending, I give my permission for the therapist to see my partner individually, if that partner so chooses.
* I have the right to prompt and reasonable responses for my questions and requests.
* During my treatment with my counselor, I shall be free from abuse, exploitation, or criminal sexual conduct.
* I have the right to participate in the planning of my mental health care.
* This consent will expire 30 days after the termination of treatment.
* I have access to the HIPAA policy.

**I understand and agree to all of the above:**

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Client name (printed)

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Signature of Client Date