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717 5th Street
Spearfish, SD 57783
605.519.5033

Consent for Counseling / Professional Disclosure Statement
Shannon Howard/Outpatient Therapist

Counseling can have many benefits. It can help you learn more about yourself, resulting in better communication in your relationships. Counseling can also help with feeling more connected to people in your life, create a sense of hope and direction, and relieve feelings of frustration, depression, and anxiety. It can give you the tools to change your feelings, thinking, and behavior to find the path that is better for you. You determine the nature, pace, and the amount of change you wish to make. I'm glad you've decided to come to counseling!

In counseling, sometimes major life decisions are contemplated, including decisions involving separation with family members, 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 examining many of their beliefs and values. Sometimes, symptoms and feelings may be intensified during the course of therapy. I will be available to discuss any of your assumptions or possible negative side effects in our work together.

Licensure/Education/Areas of Specialization:

South Dakota Licensed Professional Counselor - Mental Health, #LPC-MH30516
Qualified Mental Health Professional, SD Dept. of Social Services, Div. of Behavioral Health
National Certified Counselor - #323904
Master of Science in Clinical Counseling, 2009, University of Northern Colorado
Bachelor of Science in Psychology, 1999, University of Washington

I specialize in working with teenagers and adults on many issues including depression, anxiety, mood disorders, personality disorders, grief and loss, and relationship issues to name a few. My passion is working with women who have been through some type of trauma and are experiencing difficulty functioning in the present moment. I follow the Rules and Regulations of the South Dakota Board of Examiners for Counselors and Marriage & Family Therapists, and the Ethical Guidelines and Standards of Practice listed by the American Counseling Association (ACA).

Concerns should be shared with your counselor, and if we are unable to resolve your concerns, you wish to obtain more information, or you would like to report a complaint, you may contact the SD Board of Examiners for Counselors and Marriage & Family Therapists at PO Box 340, 1351 N. Harrison Ave., Pierre, SD 57501-0340, 605.224.1721, dss.sd.gov/licensingboards/examiners.aspx .

This information is provided as required by the Mental Health Licensing Act.
Your signature on the final page of this document indicates that you have received a copy of this disclosure statement, and you give your permission for you to receive counseling services under the terms given. What occurs inside the counseling session is confidential.

Confidentiality and its limitations:

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 of my observations or plans for our next meeting. I work to keep the information recorded brief and only what I deem necessary. If you choose to file for insurance reimbursement, I will be required to assign a diagnosis to you. If you have any questions about this, please let me know.

The information discussed during counseling sessions and all documentation is kept private and confidential. There are a few important exceptions to confidentiality, which are as follows:

- If a judge subpoenas the records, or there is a court order for the therapist to appear or produce the client's chart in a court hearing. My fee for work relating to court is $250/ hour, including time spent copying records.
- If I learn that there exists a serious threat to any person, including you.
- If there is any evidence given of suspected child, dependent adult, or elder abuse.
- If your insurance company is involved, some information will be given after you sign a release of information, which is part of the insurance form.

Contact outside of session:

On occasion, there may be a need to have contact outside of normal counseling sessions. For your convenience, you can contact me through phone, text, or email. If I am not available to take your call, please leave me a voicemail and I will get back to you within 24 hours, excluding weekends and holidays. **If you have an emergency, please call 911 or the Crisis Care Center at 605.391.4863.**

It may become useful during the course of therapy to communicate by email, text message, or other electronic methods of communication, including teletherapy. I will provide HIPAA compliant means of doing so, however, be aware that not all of these means are confidential. I require your signature on a specific consent form, for this purpose.

I do not accept friend requests or follow former or current clients on social media sites, such as Face Book or LinkedIn. Doing so can compromise treatment boundaries. I am concerned with your privacy, and believe following clients on social media compromises your privacy. Personal counseling relationships are professional, and contacts between clients and counselors are expected to be of a professional nature. Sexual intimacy between client and counselor is never appropriate.

Payment:

My standard fee is $210 for the intake (first) session and $180 per subsequent counseling sessions, if insurance is billed. My cash rate (no insurance billing) is $150 per session. Cash, check, or credit/debit card payments are accepted. In the event that my fees change, you will be given a 30 day notice.

The sessions are 50-55 minutes long. Please note, that if sessions go longer than normal, there may be an extra charge. Insurance companies usually pay the same amount per session, regardless of the length.

I am an in-network provider with some insurance companies. If you prefer, I will submit and file insurance claims on your behalf, both for in-network and out of network. Although I am wiling to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will pay for the counseling services I provide. You, as the client, are fully responsible for payment of my fees. My services are billed as Outpatient Mental Health. Please discuss any questions or concerns you have about this with me.

Cancellation Policy:

When you schedule an appointment, I am reserving time especially for you, so please give me 24 hours notice if you are not able to make your appointment. You may leave a voicemail, text, or email to cancel and/or reschedule your appointment. I charge a $60 fee for cancelled appointments with less than 24 hours advanced notice, and this fee must be paid prior to our next session. Your insurance will not cover this charge.

Having said this, if you are sick, please call to reschedule - I will not charge a cancellation fee for this reason. Your health is important to me, and you will not be equipped to do your best work in therapy if you are fighting illness. In addition, I would prefer to minimize exposure to myself, my other clients, and my family. Thank you for being mindful of this!

Ending Therapy:

Your participation in counseling is voluntary and you have the right to end therapy whenever you choose. Should you decide to end counseling prior to a planned outcome, I encourage you to talk with me about the reason for your decision in a counseling session together. I may request that you allow for one final session for us to have an ending together, to review what we've done, and to offer feedback to one another. Likewise, at my discretion, I reserve the right to end our therapy work together and provide you with appropriate referrals for other counselors you may work with for reasons including, but not limited to: failure to participate in therapy, conflicts of interest, untimely payment of fees, or belief that I may not be the best therapist to provide you what you need.

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Consent for Services Signature

Please initial each of the following and sign below:

_____I acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

_____I seek and consent to take part in treatment with the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand and agree to play an active role in the therapy processes.

_____I understand that no promises or guarantees have been made to me about the results of treatment or of any procedures provided by this therapist.

_____I am aware that I may stop my treatment with this therapist at any time. If I do, I will have to pay for the services I have already received. I understand that I may lose other benefits or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

_____I know that I must call to cancel an appointment at least 24 hours (1 business day) before the time of the appointment. If I do not cancel and do not show up, I will be charged $60 for that appointment. Exceptions include if I begin to feel sick the day of the appointment, the weather is inclement, or I have an emergency that is unforeseeable, however I must call to have the fee waived.

_____I am aware that my health insurance company or other third-party payer may be given information about my diagnose(s) and life functioning, as well as the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____ ____/____/____

Signature of client or legal representative | Printed name | Date

_____ _____

Printed name of legal representative | Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). 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 | Date

❑ Copy accepted by client or ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.