**Professional Disclosure Statement and Informed Consent**

Irwin Counseling Service, PLLC

Clint W. Irwin, MA, LPC CADC CCTP

License # 6401011162

300 W. Washington Ave, Suite 210B, Jackson, MI 49201

(517) 227-6038

**Counseling Practice:**  Welcome to our practice! We offer counseling services to all ages, adhering to a client-centered approach. We strive to create a calm and safe therapeutic environment where a collaborative relationship can be established between counselor and client. The partnership between counselor and client facilitates the ability to identify issues, create goals, and work together to achieve those goals. I believe positive change is possible and that you possess inner resources to help you live a fulfilling life. It is important you realize there are risks involved with any type of counseling. You might feel worse before you feel better. You may experience uncomfortable emotions such as anger, frustration, or fear. It is not possible to make any guarantees about the outcomes of counseling.

**Fees for Services**: If you do not have insurance, my fee is $190 per initial assessment and $150 per session. I also offer a sliding scale based on income or client ability to pay. **Session fees and co-pays are due at the end of every session**. I accept cash, check, credit, and debit. Deductible amounts will be billed to you and payment should be made within 30 days.

**Public Health Concerns:** Considering the recent public health crisis, Irwin Counseling Service, PLLC has adopted the following procedures to address in person services and/or telehealth services. However, telehealth services are also determined by insurance companies and applicable laws, so that is an issue we may also need to discuss before committing to telehealth sessions. **Risks of Opting for In-person Services:** You understand that by coming to the office, you are assuming the risk of exposure to any public health risk. This risk may increase if you travel by public transportation, cab, and/or ridesharing services.

**If You or I Are Sick:** You understand that I am committed to keeping you, me, or my staff and all our families safe from the spread of this virus. If you show up for an appointment and I or my office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate. **You will not be charged cancelation or no-show fees for cancelation of appointment if you are sick.**

If I or my staff test positive for the virus, I will notify you so that you can take appropriate precautions.

**Your Responsibility to Minimize Your Exposure:** To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and/or our families), safe from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in starting/ returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions.

* You will only keep your in-person appointment if you are symptom free. \_\_\_\_
* You will wait in your car or outside until no earlier than 5 minutes before your appointments time. \_\_\_\_
* You will wash your hands or use alcohol-based hand sanitizer when you enter the building. \_\_\_\_
* You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you will not move chairs or sit where we have signs asking you not to sit. \_\_\_\_
* You will keep 6 feet and there will be no physical contact (e.g. no shaking hands with me or staff).
* If you are bringing your child, you will make sure that your child follows all these sanitation and distancing protocols. \_\_\_
* You will take steps between appointments to minimize your exposure any current public health crisis. \_\_\_\_
* If you have a job that exposes you to other people who are infected, you will immediately let me, or my staff know. \_\_\_
* If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me, and my staff know. \_\_\_\_
* If a resident of your home tests positive for the infection, you will immediately let me, and my staff know, and we will then resume treatment via telehealth. \_\_\_
* Wearing a mask is at yours and my staff’s discretion. \_\_\_\_

**My Commitment to Minimize Exposure:** My practice has taken steps to reduce the risk of spreading the virus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

**Your Confidentially in the Case of Infection:** If you have tested positive for virus, I may be required to notify local health authorities that you have been in the office. If I must report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason (s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

**Court Appearances:** The only time I will agree to court appearance is when subpoenaed by the court and then the following applies: reports and court appearances require professional time for which I charge a rate of $175 per hour, payable in advance in the form of a retainer fee of $2000, to account for time spent preparing for the court appearance, time spent in court, and time spent commuting to and from the courthouse. Court letters are $50 per letter. All fees will be subtracted from retainer fee, if services continue after retainer has been used, appropriate billing will apply.

**Court Ordered Treatment:** If ordered for individual, couple, substance abuse, and/or family counseling, the client and/or parent are responsible to cover the cost of the session, which is $125 before 5 pm and $150 after 5pm and required paperwork $50 per letter. However, if the court ordered therapy is due to custody conflict and/or ongoing legal case the non-custodial parent will be responsible for the session payment. Furthermore, if the court orders family counseling due to a parenting time related issues and requires court appearance and documentation, there will be a $2000 retainer before any services are conducted. This retainer will cover travel, court appearances/documentation, communication with both parents and their lawyers, and communication with anyone connected with the case.

Counseling sessions might be covered by insurance and/or self-pay. Furthermore, if the custodial parent fails to comply with order and/or fails to deliver the child(ren) to the session, the custodial parent will be responsible for the payment, which is not billable to insurance so this charge will be billed directly to the custodial parent. The session fee will also be due if the child and custodial parent show and the non-custodial parent does not. A record of all payments will be recorded by the therapist and/or employee of Irwin Counseling Service, PLLC. If there is a need to reschedule, please do so with **24-hour notice**, by calling 517-227-6038 and/or leave me a voicemail. Barring emergencies such as hospitalization or death which will require appropriate documentation, cancellations with less than 24-hour notice will incur $125 before 5pm and $150 after 5pm fee. This fee will be billed directly to you, and is not billable to an insurance company, and will be due at your next appointment or within 30 days of the billing date. Unpaid bills will accrue interest every 30-day billing cycle, with an 18% APR.

**Professional Roles/Boundaries:** I have many distinct roles in the local community. You may, therefore, encounter me outside the counseling setting. When this happens, I will protect your confidentiality by not acknowledging our counseling relationship unless initiated by you or, for professional reasons, warranted by me. For that same reason, I will not be able to “friend” or “follow” you on social media.

**Client Rights:** You have the right to refuse any suggestion(s) I may give you during your counseling sessions. You have the right not to talk about something if you don’t want to. You also have the right, at any time or for any reason, to decide you do not want to continue counseling. In that case, I request that you inform me of your decision and schedule a final session to bring closure to our work together.

**Missed or Cancelled Appointments:** Please call whenever you need to cancel an appointment. Missing a scheduled appointment without notification greatly inconveniences other clients who are waiting to get in for an appointment. I reserve the right to charge you up to $50 for appointments that are not canceled 24 hours in advance. This policy does not apply to **Court Ordered Treatment.**

**Confidentiality:** Your therapy sessions are strictly confidential except under certain circumstances when I am required by law to report information you have shared. These exceptions to confidentiality include:

* Report of child or elder abuse or neglect
* The intent to harm yourself or someone else
* Court-ordered subpoenas
* Report of your intent to commit a felony

I may also consult with other professionals about your circumstances and how I might proceed to help you, but I will do so without using your name or any other identifying information. You have the right to ask me not to consult with anyone.

Please be informed that your health insurance company requires that I provide them with information pertaining to your counseling sessions. I must give a clinical diagnosis. Sometimes I must provide additional information such as treatment plans or summaries. I will make every effort to release only information that is necessary. By signing this agreement, you agree that I can provide requested information to your insurance carrier.

**Consent for Email and/or Text Message Communication:** Email and text messaging allows me to exchange information efficiently for the benefit of clients. However, email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

If you agree to have email and/or text messages sent to you that contain your health information (such as corresponding about scheduling, providing invoices and receipts for services), please sign the Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your services with me in any way.

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

**Signature**

**Questions or Concerns:** If you have any concerns about this disclosure statement or the counseling provided by this agency, please feel free to discuss them with me. You may also direct your concerns to

Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, Investigations & Inspections Division, P.O. Box 30670, Lansing, MI 48909. Phone: 517-241-0205.

**Consent to Treatment:** I understand the above issues and agree to receive counseling services from Irwin Counseling Services, PLLC. By signing below, I also acknowledge a copy of the Privacy Practices has been made available to me or I have had an opportunity to review the Privacy Practices for this agency.

**Assignment of Benefits/Release of Information:** I hereby authorize payment directly to the named provider of any medical benefits payable to me under the condition of my policy for services rendered. I hereby give consent for release to authorize person of financial and medical information concerning care, treatment, and charges as may be required to complete all claims for benefit.

I understand it is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by insurance the day and time services are provided.

**I understand that I am responsible for all charges, regardless of insurance coverage. Initials \_\_\_\_\_\_\_\_\_**

I have read, understood, agree, and consent to the above conditions of service stated. I have also received the notice of privacy practices on this date and I have had the opportunity to ask questions about and understand these policies.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date**