Counseling Agreement
Laura Duke, MSW, LCSW

Please read the following information carefully. If you have any questions, do not hesitate to let me know.

Confidentiality: Our counseling sessions and your records are **strictly confidential** except where state law requires the reporting of threats of violence, harm to self or others, or child abuse and neglect (from evidence or suspicion), when a child witnesses domestic violence, when the courts subpoena information, and when information is needed for billing. As an effort to improve services, I may at times consult with other professionals about therapy. I can assure you that I make every effort to maintain confidentiality during case consultation.

Insurance: If your insurance company is paying in part or full for your session, they sometimes have the right to gain information regarding your counseling sessions. This varies with different insurance companies. If there is any question about this it is suggested you contact your insurance company so that you know what access they are allowed to have as part of your policy agreement. Additionally, in order to file through insurance it is required that I give you a diagnosis. It is important that you understand that not all diagnoses are covered under any given insurance plan and that when a diagnosis is given it becomes part of your records with the insurance company.

Professional Ethics: It is also important that you understand our relationship is kept strictly professional. My relationship with you as your therapist prevents me from maintaining any kind of social relationship with you. If I should see you in public I will respect this confidentiality and not indicate that I know you. Unless you approach me, I am unable to acknowledge you as someone I know as a client. I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards set forth by the National Association for Social Workers. If you have a complaint which you believe needs to be registered with my governing board you can contact the Virginia Board of Social Workers referencing my license number: **VA0904006373.**

Your Rights: It is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results. Your sessions are your time to discuss any topics which you feel appropriate. You may end our counseling relationship at any time. Although, I do ask that you participate in a closure session. You also have the right to refuse or negotiate modifications of any of my suggestions that you believe may be harmful. At any time, either you or I may initiate discussion of possible positive or negative effects of entering or not entering counseling, continuing or not continuing counseling, and/or using or not using certain techniques.

(OVER)

It is not unusual that as the counseling process progresses you may feel as though things are getting worse before they get better.
If at any time for any reason you are dissatisfied with my services, please let me know. Should you and/or I believe that a referral is needed, I will provide you with some possible referral sources. A verbal exploration of alternatives to counseling will also be made available upon your request.

Payment and Cancellations:
A 24-hour notice is required for all cancellations. You will be charged a fee of $75.00 for missed appointments not canceled or rescheduled 24 hours in advance.
Being aware that there may be potential for emotional strains, stresses, and life changes as a result of counseling, I agree to enter the counseling process. I understand that Laura Duke does not guarantee any particular results or outcomes from the counseling process.
I am aware that Laura Duke does not offer an emergency services, and I have been informed to call Region Ten emergency services at 434-972-1800 or 911 in the event of an emergency.
The payment policies have been discussed with me and a fee of $150.00 per 45 minutes has been set. I agree to provide 24 hour notice for cancelled appointments. By signing this document I agree that if I have an account balance, it will be charged to the credit card on file.

I hereby grant my permission for any counseling, testing, or diagnostic evaluation that may be needed in counseling. I have read the above and agree to all stated terms.

_____
Client/ Date

_____
Laura Duke, MSW, LCSW /Date

I have reviewed a copy of the HIPAA Notice of Privacy Practices and am aware that I can request a copy of HIPAA policies.

Client Name Printed/ Date: _____

Client Signature/ Date: _____

Witness/Date:_____