**Hope Counseling and Psychotherapy**

Client Consent for Treatment Form for Clients of

Angela F. Montgomery, LPC, NCC

360-305-6900

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**INSTRUCTIONS: PLEASE READ THIS CLIENT CONSENT FOR TREATMENT FORM IN IT’S ENTIRETYAND RETAIN A COPY FOR YOUR RECORDS. PLEASE SIGN AND DATE THE LAST 2 PAGES AND BRING TO YOUR FIRST SESSION.**

**ABOUT THE COUNSELOR**

**Credentials –** Ms. Montgomery holds a master’s degree in counseling from Liberty University earned in 2011 and completed a 4000-hour post graduate Residency. She is a Licensed Professional Counselor in the Commonwealth of Virginia and is a National Certified Counselor, Distance Credentialed Counselor and a Certified Clinical Trauma Professional. Ms. Montgomery has been approved by The Virginia Board of Counseling to provide clinical supervision to Residents in Counseling who are working toward licensure.

Licensing Regulations – The Virginia Board of Counseling regulates all Counseling practices. Complaints may be directed to:

**The Virginia Board of Counseling**

Perimeter Center, 9960 Mayland Drive, Suite 300

Henrico, VA 23233-1463

Phone: (800) 533-1560; Fax: (804) 527-4435

E-mail: coun@dhp.virginia.gov

Ethical Guidelines – Ms. Montgomery adheres to the current ACA Code of Ethics (2009), which may be viewed electronically at www.counseling.org. You may also contact the ACA directly at: **American Counseling Association**

5999 Stevenson Ave., Alexandria, VA 22304

Phone: (800) 347-6647; Fax: (800) 473-2329

E-mail: [www.counseling.org](http://www.counseling.org)

**EMERGENCIES**

In the event that you need emergency services and cannot contact us, please call the Crisis Hotline at 627-LIFE or your local Fire-Police-Rescue at 911.

**IF YOU HAVE A COMPLAINT**

We believe in professional responsibility. If you think you have been treated unethically and cannot resolve this problem with us, we encourage you to contact the National Board of Certified Counselors (336-547-0607) and/or the Virginia Board of Health Professions (800-533-1560) to lodge a complaint.

**ROLE OF DIAGNOSIS**

Your counselor uses the Diagnostic and Statistical Manual-Text Revision (5th Edition) published by the American Psychiatric Association (2014) to assist in coding any diagnosis we may determine to be appropriate to your situation. Diagnosis serves the purpose of providing a framework upon which we can view your situation and plan treatment.

**CONFIDENTIALITY AND PRIVILEGE**

In general, the privacy of all communications between a client and a psychotherapist is protected by law, and your counselor can only release information about our work to others with your written permission. But there are a few exceptions.

* In most legal proceedings, you have the right to prevent your counselor from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your counselors testimony if he/she determines that the issues demand it.
* There are some situations in which your counselor is legally obligated to take action to protect others from harm, even if your counselor has to reveal some information about a patient’s treatment. For example, if it is believed that a child [elderly person or disabled person] is being abused, your counselor must [may be required to] file a report with the appropriate state agency.
* If it is believed that a client is threatening serious bodily harm to another, your counselor is [may be] required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, your counselor may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
* Your counselor may occasionally find it helpful to consult other professionals about a case. During a consultation, your counselor will make every effort to avoid revealing the identity of the client. The consultant is also legally bound to keep the information confidential. If you don’t object, your counselor will not tell you about these consultations unless it is determined that it is important to your work together.
* While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have at your next meeting. Your counselor will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and your counselor is not an attorney.

**PARKING, OFFICE SPACE, AND BOUNDARIES**

Please park in the designated parking area. Please inform us ahead of time if additional privacy is necessary so we can work with you to meet your needs. We strive to create a peaceful and conducive environment for our work. You are welcome to enter the premises and be seated in the private counseling area provided. We ask that you remain in the designated area for the purpose of privacy and it helps us to maintain good professional and physical boundaries between our public areas and our private counseling space. Please let us know if anything in the environment becomes distracting or affects your ability to work. We will make every effort to accommodate your needs.

**SCHEDULING, LENGTH OF SESSIONS, CANCELLATIONS**

We schedule sessions with our mutual agreement. Sessions are 50-70 minutes in length unless otherwise agreed upon. If you are unable to keep an appointment, please cancel or reschedule at least 48 hours in advance to avoid being charged a missed appointment/late cancellation fee.

**NO SHOW/LATE SHOW/CANCELLATION POLICIES**

Our goal is to manage our time wisely to serve our clients better. When timely (48 hours or more notice) cancellations occur, it is possible to offer open appointment times to clients on the **appointment waiting list**. We sincerely appreciate your cooperation and understanding of the following policy, which is in effect to encourage timely notice of cancellations:

**POLICY: Clients are responsible for a $60 charge for each No Show/No Call event, and when an appointment is cancelled with less than 48 hours’ prior notice.** **Same day cancellations will be charged at the full contracted amount.** The client agrees to pay this charge at or before the next appointment. These charges also apply in the event that a client comes to his or her appointment so late that there is not sufficient time remaining to engage in a therapeutic process. (This will not apply in those instances when the counselor is also running late due to an emergency or other unforeseen circumstance). These charges may be appealed if extenuating circumstances exist that prevent timely notification of cancellation.

**INCLEMENT WEATHER/COMMUNITY/COMMUNITY EMERGENCY CLOSING POLICY**

In an effort to protect client safety, we close our office whenever Public Schools close due to inclement weather or other community emergencies. If a weather or emergency event falls on a Saturday, we follow the closing schedule of Tidewater Community College.

**MESSAGES**

Messages may be left on our voice mail at any time. Voice mail is checked regularly between 8am and 7pm during days the practice is operating. We will return your calls as soon as possible. Please indicate your preferred method of communication on your **New Client Form or in your message**.

**PHONE CALLS**

Your counselor is available for phone consultation **only** in **the event** **of an emergency**. An emergency **is a life threatening need or when immediate hospitalization is indicated**. Unfortunately, the demands of our practice prevent the provision of any other form of unscheduled counseling services via telephone. If you need or want to speak to our counselor before your next scheduled session, please call for an earlier appointment time. We will strive to set this appointment within as brief a period of time as possible, and your needs will be relayed to the counselor.

**EMAILS AND TEXT MESSAGES**

Email and text messages are not useful methods of communication for counseling purposes. **Please do not send private or personal information to us via email or text**. We cannot guarantee the confidentiality of any communication sent to us in these ways, nor can we guarantee that emails and texts will be received or read. Likewise, we can’t respond to questions or counseling needs described in emails or texts (ethical concerns and severe limitations created by security issues, time lapses, and potential technological problems make this problematic). You may elect, at your own discretion, to email requests for appointments and cancellation notices (please understand that cancellations must be **received** by our office at least 48 hours before your appointment time, and that email delivery times can be affected by many factors). Please do not include personal information about your status or case in these emails. **Please, never use email or texting to communicate an emergency or crisis.**

**FEE FOR SERVICES**

The fee for Subpoena for court or other legal proceedings (e.g. deposition) is $1000 per day for any part of a day for each day the therapist is required to be present.

Document Requests: A $80 per hour fee will be charged to create, compile, and deliver document requests and communication with other parties outside of the counseling session. Examples of documentation are letters, record requests, record summaries, letters for work/school, FMLA forms, recommendations, subpoenas and other documents or communication/telephone calls with other professionals’/family members; etc. In the event that we cannot complete any needed documentation during your scheduled appointment time, Ms. Montgomery will be required to do so outside of your regular session. If you need documentation completed for you to assist you, PLEASE request it at the beginning of your session so that we can attempt to complete the paperwork during your session time.

**PAYMENT OF OUTSTANDING BLANCES/MISSED APPOINTMENT FEES AND SCHEDULING**

We are committed to helping people find healing and growth and work hard to facilitate that process. A growing account balance can create significant stress for the client and compromise our work. What appears to be helpful (e.g. allowing a client to pay later) can actually sabotage our progress. Likewise, research repeatedly bears out the fact that clients who don't pay for services don't engage as fully in the process and receive less benefit in the end. Payment is required in full at the time services are provided (unless other arrangements have been made in advance. Therefore, we do not bill clients for balances, use payment plans, or provide sliding scale fee schedules. If you need this kind of accommodation, please let us know. We can refer you to a competent clinician in a subsidized setting where these options are offered.

To prevent the accumulation of outstanding balances, it is our policy that clients must have a "zero" balance (owe no outstanding fees) before they can schedule an appointment. This policy includes payment of fee balances and any Missed Appointment Fees. We do not want fees to become a hardship or hindrance to progress and hope you can understand the need to comply with these policies so our work can be more productive. If you accrue an outstanding balance or Missed Appointment Fee, please submit your payment at the time you schedule your next appointment.

We believe in the fairness and honesty of our clients and expect that we will be paid outstanding balances in timely ways. However, those few clients who default on payments of fees for services rendered are responsible for all legal and administrative fees related to collection fees related to collection on defaulted accounts. Your signature on this document signifies your agreement to this policy.

 **NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (HIPPA Notice)**

 **THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

As a Licensed Professional Counselor approved by the State of Virginia, Ms. Montgomery creates and maintains treatment records that contain individually identifiable health information about you. This notice, among other things, concerns the privacy and confidentiality of those records and the information they contain.

**USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION**

Federal privacy rules and regulations allows mental health professional to use or disclose your personal health information (without your written authorization) in order to provide treatment to you, for billing and related business purposes, to conduct health care operations, and to disclose your protected health information to any health care provider to facilitate their treatment activities.

**NOTICE OF PRIVACY PRACTICES**

This may include consultations or referrals with other licensed health care providers about your condition, the coordination and management of your health care among health care providers or a third party, communications with insurance carriers and billing agents, and oversight organizations that work to ensure that services are provided in a manner that complies with applicable laws, regulations and professional ethics.

Ms. Montgomery may be required or permitted to disclose your personal health information without your written authorization in other circumstances including, but not limited to the following:

* When compelled by a court, board, commission, administrative agency, arbitration panel, or search warrant as long as the request is lawful and follows the guideless established by law and the regulations of the requesting entity.
* For the purpose of Reporting Child or Elder Abuse, Neglect or Domestic Violence to appropriate authorities
* To report the need for additional services if it is believed you have become a danger to your own safety or to the safety of other persons.
* To contact you to provide appointment reminders or information about alternatives or other health-related benefits and services that may be of interest to you.
* Uses or disclosures of your personal health information (without your authorization) will be limited to the minimum necessary to accomplish the intended purpose of the use or disclosure.
* If you have a concern about the privacy of your records or any other element of this policy, you may complain to the Secretary of the U.S. Department of Health and Human Services. Please submit complaints in writing, to the Secretary of the U.S. Department of Health and Human Services at the following address: U.S. Department of Health & Human Services 150 S. Independence Mall West - Suite 372 Philadelphia, PA 19106-3499 (215) 861-4441; (215) 861-4440 (TDD) (215) 861-4431 FAX

**CLIENT’S RIGHTS**

**You Have the Right to:**

* Request restrictions on certain uses and disclosures of protected health information. However, Ms. Montgomery is not required to agree to a restriction you request. We will discuss this issue if this occurs.
* Request and receive confidential communications of your private health information by alternative means and at alternative locations.
* Inspect and/or obtain a copy of protected health information and billing records used to make decisions about you for as long as the protected health information is maintained in the record. Ms. Montgomery may deny your access to protected health information under certain circumstances, but in some cases you may have this decision reviewed. On your request, Ms. Montgomery will discuss with you the details of the request and denial process.
* Generally, have the right to receive an accounting of any disclosures of your protected health information. On your request, Ms. Montgomery will discuss with you the details of the accounting process.

**THERAPIST’S DUTIES**

Ms. Montgomery is required by law to maintain the privacy of your Personal Health Information and to provide you with a notice of my legal duties and privacy practices with respect to Personal Health Information. Ms. Montgomery may reserve the right to change the privacy policies and practices described in this notice. Unless you are notified you of such changes, however, Ms. Montgomery is required to abide by the terms currently in effect. In the event the practice policies and procedures are revised, Ms. Montgomery will provide you a copy of these revisions at the next appointment.

**Dual Relationships –** Psychotherapists do not participate in barter or gift giving. Furthermore, the relationship is a professional one and as such Ms. Montgomery cannot socialize with you outside of therapy. If an accidental meeting occurs, she will not approach you and request that you not approach her. Please be aware that she is not permitted to engage with current or past clients through any form of technology or social media sites. This arrangement helps to ensure your confidentiality.

**Minors** -- If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is Ms. Montgomery’s policy to request an agreement from parents that they agree to give up access to your records. If they agree, she will provide them only with general information about your work together, unless she feels there is a high risk that you will seriously harm yourself or someone else. In this case, she will notify them of her concern. She will also provide them with a summary of your treatment when it is complete.

**Closing Statement -** Acknowledgement of Policies and Signatures

**By signing this document, I indicate that I have reviewed, understand, and agree to comply with the policies of this disclosure statement/agreement. I acknowledge receipt of a copy of the Hope Counseling and Psychotherapy HIPPAA Notice and Consent to treatment for myself or my minor child. My signature also serves as a release to allow Hope Counseling and Psychotherapy to communicate relevant information to my insurance company (if applicable).**

**I hereby certify that I am over the age of eighteen, have read, understood, and consented to the above terms and conditions for counseling and agree to undertake psychotherapy with Angela Montgomery, LPC, NCC. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.**

**Confidential Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is a voicemail message acceptable \_\_Yes \_\_No**

**Alternative instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Client**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Guarantor/Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payment and Insurance Methods Selection and Agreement**

Please carefully read the statements below and check statement that applies to you:

**\_\_\_\_I will be using medical insurance, and will not pay for services out of pocket outside of my co pay**. I understand that I am responsible for all fees for services provided to me. I have read, understand, and agree to comply with the Hope Counseling and Psychotherapy fee policies, and the No Show/Cancellation Policy. I also acknowledge receipt of the **Notice of Privacy Practices for Protected Health Information. Please note:** If you choose to use insurance you must have a mental health diagnosis that is treatable and billable under your insurance plan. You are responsible to check your deductible and co pay fees before your first session.

\_\_\_ **I will not be using medical insurance, and will pay for services out of pocket**. I understand that I am responsible for all fees for services provided to me. I have read, understand, and agree to comply with the Hope Counseling and Psychotherapy fee policies, and the No Show/Cancellation Policy. I also acknowledge receipt of the **Notice of Privacy Practices for Protected Health Information.**