

**INFORMED CONSENT AND PSYCHOTHERAPY AGREEMENT**

Heart and Mind Counseling strives to provide high-quality mental health services to help improve the life of every patient we encounter. The following will explain our policies and procedures and will serve as a contract between the clinician and the patient.

I am voluntarily seeking counseling and I am committed to working with my therapist to successfully resolve my issue(s). My therapist/counselor will meet with me regularly, listen attentively, work with me to accomplish mutually stated and agreed upon goals. My counselor will treat me with respect and dignity. I understand that my counselor is bound by the legal and ethical standards of his/her profession. This includes confidentiality, which means that my counselor will not reveal any information about me except in the following situations:

 Medical Emergency

Threats of Suicide/Homicide

Threats of Bodily Harm to Self or Others

Suspected Child Abuse or Neglect

Suspected Abuse of the Elderly or Disabled

I understand that I have a right to review my records at any time, and that if I have questions or concerns, I can reach my therapist through the contact information provided for me. In case of an emergency, I will call 911 or go to the nearest hospital emergency room. Should my therapist become incapacitated, an authorized person will contact me and may refer me to another therapist. My records will continue to remain confidential unless otherwise authorized by me.

**Sessions**

My sessions will be scheduled as agreed upon by myself and my therapist for approximately 45-55 minute sessions as needed. The optimal number of sessions is typically 10-16 weeks, but may extend to lengthier treatment depending on my or my child’s needs. The therapist will discuss termination of therapy with me beginning at intake and several weeks prior to discharge.

1305 E Main Russellville, AR 72801 | 479-231-1346 | www.heartandmindcounselingar.com

**Expectations for my child in therapy**

My child will be allowed to explore the play room, choose their avenue of play and become comfortable in the play room environment. The therapist will step back from a directive role and allow my child to dictate the direction of the session when deemed necessary and therapeutic by the therapist. The play therapy room is meant to be an environment free of danger and judgment. The rule of the play therapy room is this: my child may not harm self or therapist. Any other limits the therapist views as necessary will be set as needed.

**Risks of Therapy**

I realize that participation in counseling can be beneficial both for me and those with whom I am in relationship, but that it does not guarantee a cure of symptoms. Some of the risks of therapy include dealing with uncomfortable emotions and topics. While self-disclosure of relevant information is beneficial to the counseling process, I also understand that counseling may involve discussing relationship, psychological and/or emotional issues that may, at times, be distressing. I understand that my situation and/or emotional/mental state may get worse before it gets better due to the distress that may be experienced throughout the process of therapy. Although there may be potential for these risks, there is an abundance of research showing the benefits that result from therapy. I am aware of alternative treatment methods available to myself/my child.

**Confidentiality**

The law and professional counseling standards require that my therapist keep notes regarding each of my sessions. If my child is attending therapy, I am allowed to have access to my child’s counseling records. Upon my request, the therapist will set up a meeting to discuss and explain these records. Due to the fact that children feel increased freedom to express themselves when there is no worry of parental reaction, it is best to keep some specific content of my child’s session confidential. The exception to confidentiality is my/my child’s expression of desire or intent to harm self or others or reports of abuse/neglect.

**Mandated Reporting**

As a licensed professional counselor, my therapist is a mandated reporter. This means that my therapist is required by law to report suspicion of abuse to the Department of Human Services.

**Payment**

Payment is expected on the day that services are rendered. This includes any co-pay for insured clients and the entire session fee for private-pay clients. Payments can be made by debit card, credit card, check, or cash. If a check does not clear due to insufficient funds or for any other reason, the patient will be billed for any related bank fees incurred as a result of the insufficient funds. My therapist accepts private pay, private insurance and Medicaid.

**Cancellations and No Shows**

The time that you schedule with a clinician is set aside only for you.If you need to cancel a scheduled appointment, please do so at least 24 hours in advance. **I will notify my counselor at least 24-hours before my appointment if I need to cancel or reschedule my session. After 2 No Call/No Shows, I will forfeit my scheduled session time and be billed for any future No Call/No shows at a rate of $50.**

**Court**

In the event that my testimony is subpoenaed for court, a $200/hour fee with an 8 hour daily minimum will be charged for my expert witness testimony. This fee will include travel time to and from my office and due even if court is postponed. This fee will be charged regardless of whether or not I am called to testify due to the clearing of my schedule to attend court. Payment is due one week prior to my court attendance and additional court attendance hours will be billed accordingly. I am able to write a recommendation letter for a $60 charge. Payment will be accepted by Money Order to Heart and Mind Counseling, LLC.

**Psychological Testing**

Psychological testing is sometimes necessary in diagnosing and treating a child most effectively and to meet the individual needs of the child. Should the therapist see that testing is necessary or would be beneficial in treating my child, we will discuss this possibility and a referral will be made upon my approval.

**Emergency Procedures**

*In the event of an emergency, please go to your nearest emergency room or call 911. If you have a concern between sessions which is not an emergency (risk/threat of harm to self or others), you may text me at 479-231-1346 and I will schedule a session at the earliest available session to discuss the concern.*

**Correspondence**

Counseling issues are best handled in a scheduled counseling session. If you have correspondence with your therapist over email, please note that email is not a secure medium for discussing health-related information. We suggest limiting email correspondence to administrative, non-clinical content only. All email correspondence will be inserted into the medical records and saved for future reference.

**Friending/Following**

In order to preserve the appropriate boundaries of a therapeutic relationship**,** our therapists do not accept friend or contact requests from current or former clients on any personal social networking site (Facebook, Instagram, LinkedIn, etc.).

**The Clinic Blog / Website / Podcast and Other Web Content**

We maintain a blog on our website to offer information and resources to the families we serve and the public in general. In order to offer this resource to our clients without jeopardizing our confidentiality and privacy agreement, we never post stories about our clients or our experiences in therapy, and we do not correspond through the “comments” sections on the blog page. Any comments left by readers are for other readers, and are not necessarily read by the authors. Our posts are not meant to replace therapy or consultation with a mental health professional.

**Professional Records**

You have the right to receive a copy of your records (either in print or electronically) if you make a request in writing. Copies of client records are available for an administrative fee that will reflect actual cost of labor, paper copies, usb (for electronic copies), postage or other materials. However, the involved therapist may ask to discuss the request prior to releasing the records. Therapists can deny record requests if deemed harmful to the client. In such scenarios, you have the right to request a second opinion and another therapist will review the request.

My therapist has answered all my questions about counseling satisfactorily. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave counseling at any time, although I have been informed that this is best accomplished with my therapist.

I have read and understand the above information. If I have questions, I will contact my therapist at Heart and Mind Counseling to gain further information. I have received a copy of the HIPAA Privacy Policy and the other pertinent information needed to receive services through Heart and Mind Counseling.

I have read, understood and agree to the above. I give permission and consent for Heart and Mind Counseling to provide counseling services to myself (or my child/children) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

Parent or Guardian Signature Date

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

Relationship to Child Therapist Signature