7205 E. Southern Ave #103
Mesa, AZ 85209
Office #: 480-687-4321
www.refinedmindshealth.com

Valerie L. Wilson, LMT, LPC
Email: refinedmindshealth@gmail.com

Informed Consent for Assessment and Treatment

We want to welcome you to our practice at Refined Mental Health and Wellness. We are pleased that you have chosen our services. To assist you in understanding the responsibilities and expectations involved in the counseling relationship, we would ask that you read and sign the following informed consent. At the close of our initial session if you choose to continue counseling, you may request a copy for your personal reference.

Your session is with Valerie Wilson, the owner and licensed professional counselor of Refined Mental Health and Wellness. Valerie has earned her Master's degree in Professional Counseling and a Bachelor's degree in Psychology with a concentration in Christian Counseling from couples counseling. She enjoys working with at-risk adolescents and young adults. Valerie specializes in women's issues, anxiety and depression, domestic violence, substance abuse, spiritual integration, and relationship struggles including marriage, family, divorce care, re-marriage, and blended family issues.

As a client of Refined Mental Health and Wellness, your case will be reviewed and discussed with clinical consultants in a confidential manner on a routine basis. We reserve the right to refer a client to another therapist, or appropriate resource at any time, if his or her needs in therapy are not a good match for her skills or experience.

One of the distinctive aspects of to Valerie's practice is her commitment to provide quality professional Christian counseling to those who desire such an emphasis. It is not essential that her clients share her Christian beliefs, but you have a right to know that her values are rooted in her faith in Christ. She is committed to providing a safe environment in which her clients experience the freedom to explore their own beliefs and make their own choices regarding life and relationships.

Valerie's desire is to support and not hinder this process. The emphasis on quality counseling is based on professional training, and is continually being expanded through ongoing involvement in the continuing education process through seminars, research, supervision, networking with other professionals, and personal reading and study. The Christian emphasis is based upon reliance on the Bible as the ultimate source of truth, and in the supernatural power of Jesus Christ and the Holy Spirit to transform lives. This does not imply that everything done in the counseling session will be of a "spiritual" nature; rather, this will be the framework upon which she will implement various techniques and tools as they appear to be most beneficial for the specific individual.

Financial. Payment is expected at the time the service is rendered. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. Currently, the fee for an initial assessment is $125.00, and the fee for a 50 minute counseling session is $125.00. In addition to the basic session and assessment fees, there may be other fees for additional services such as psychometric testing, telephone counseling, books and materials, etc. There will be a $38.00 fee for checks that are returned as non-sufficient funds or non-payable. We reserve the right to change our fees with 30 days notice. You have the right to be informed of all fees that you are required to pay and our refund and collection policies. Please discuss these with us if you have a concern.

Insurance. We are currently a provider with BCBS, Aetna, Cigna, and United Healthcare/ Optum. If you are using an insurance program that is not listed, we will supply you with a superbill that you can turn in to your insurance company for possible reimbursement. In all cases, however, payment for services is due at the time of service and is ultimately the responsibility of the client, not the insurance company.

Availability of Services. Our practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to the local hotlines (Empact– 480-784-1500, Banner Help line - 602-254-4357, ValueOptions – 602-222-9444). Established clients with an urgent need to make contact may call me, but an immediate response is not guaranteed. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation.

Appointments. Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. We reserve 50 minutes for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, we ask that you notify us a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. ***You will be financially responsible for appointments you fail to cancel in accordance with this policy.***

Appointment availability varies with the client load at the time. High demand appointment times are likely to be sporadic in their availability. We reserve the right to limit our commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload. ***Our office is not able to do reminder calls. Therefore, please make a note of the date and time of your next appointment, whether it is made over the phone or in person.***

Electronic Counseling. While counseling sessions are available through Skype, Zoom, and similar platforms which claims to be HIPAA compliant, we cannot guarantee complete privacy and confidentiality during sessions. Our office utilizes cellular to devices to communicate with clients, which are not encrypted to protect privacy. The disclosure of personal history information (PHI) is prohibited except for scheduling and confirming appointments.

Privacy, Confidentiality, and Records. Records are the property of Refined Mental Health and Wellness. Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statues. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved.

We also participate in a process where select cases are discussed with other professional colleagues to facilitate our continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods. There are also numerous other circumstances when information may be released including when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against us, to comply with worker compensation laws, to comply with the USA Patriot Act and to comply with other federal, state or local laws. The rules and laws regarding confidentiality, privacy, and records are complex. ***Request for Records - Our agency requires a signed written notice before copies of records or in order for records to be sent to another party. Our agency has up to 10 business days to fulfill the request. The fee for copying a chart is $20 for the first twenty pages and $0.25 for each additional page.***

Purpose, Limitations, and Risks of Treatment. Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. Of course, the potential for a divorce is always a risk in marital counseling.

Treatment Process and Rights. Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal. The recording of any counseling session is strictly prohibited without the written consent of the counselor and client. This includes any type of audio or video devices.

Our Relationship. The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time togethersocially. The purpose of these boundaries is to ensure that you and your therapist are clear in your roles for treatment and that your confidentiality is maintained.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with us about it. It is never our intention to cause this to happen to our clients, but sometimes misunderstandings can inadvertently result in hurt feelings. We want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

Consent for Evaluation and Treatment. Consent is hereby given for evaluation and treatment under the terms described in this consent document. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature: ____ Date: ___________

In the case of a minor child, please specify the following:

Full name of minor : ___________________________ DOB _________ Relationship: ______

Therapist Signature: ____ Date: _______________

For office use only - verification that client has read and understands informed consent document

Authorized Representative:_________________________________ Date: _______________

Therapist Name: ____

7205 E. Southern Ave. #103
Mesa, AZ 85209
Office: 480-687-4321
www.refinedmindshealth.com
Valerie Wilson, LMT, LPC
Licensed Professional Counselor

Informed Consent for In-Person Services During Covid-19 Public Health Crisis

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health warnings and trends. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us in addition to our original Informed Consent agreement provided at the beginning of our counseling.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the COVID-19 virus or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

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 our families, [my other staff] and other patients) safe from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our 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. _____
- If you believe you have a temperature above 100 or if you feel feverish at all, you will cancel the in-office appointment. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. ____
- You will wash your hands or use alcohol-based hand sanitizer after routine handling of common items before, and/or during your time at the office. _____
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit. _____
- You will keep appropriate personal distance with 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 of these sanitation and distancing protocols. _____
- You will take steps between appointments to minimize your exposure to COVID. _____
- If you have a job that exposes you to other people who are infected, you will immediately let me [and 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 virus, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth. _____

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus 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.

If Either One of Us is Sick

You understand that I am committed to keeping you, me, [my staff] and all of 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.

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

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to 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.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

______________________________	______________________
Client	Date
______________________________	______________________
Counselor	Date

Client Information:

Name: ____ Date of Birth:____________________
Street Address: ____________________________________ S.S.#: __________________________
City:__________________State:________Zip: __________ Home Phone:____________________
Employed by:_______________________________________ Work Phone:_____________________
Marital Status: Married___ Divorced___ Single___ Cell Phone:______________________
Separated ___ Widowed ___ Email __________________________

Responsible Party Information:

Name: ____ Date of Birth:____________________
Street Address: ____________________________________ S.S.#: __________________________
City:__________________State:________Zip: __________ Home Phone:____________________
Employed by:_______________________________________ Work Phone:_____________________
Email ____ Cell Phone: ____________________

Spouse Information:

Name: ____ Date of Birth:____________________
Street Address: ____________________________________ S.S.#: __________________________
City:__________________State:________Zip: __________ Home Phone:____________________
Employed by:_______________________________________ Work Phone:_____________________
Email ____ Cell Phone:______________________

Children: (Name and Birthdate)

____

____

____

Referred by: ____
Name & Contact Information

☐ Check box if we may contact the referral source with a letter of appreciation.

Previous counseling experience:____

What do you hope to gain from therapy?____

____

Signature:____Date:___________________________

7205 E. Southern Ave. #103
Mesa, AZ 85209
Office: 480-687-4321
www.refinedmindshealth.com
Valerie Wilson, LMT, LPC
Licensed Professional Counselor

Payment Agreement

Please read the following and fill out the form completely. Once we have received your completed Payment Agreement, we will contact you to schedule further appointments.

- By completing and signing this Payment Agreement, you are indicating that you understand and agree to provide a valid credit card number, with expiration date, for payment of future therapy sessions, appointments, or other fees.
- Your signature indicates you understand that if you do not attend a scheduled appointment, your credit card will be charged the regular cost of the session you reserved unless you cancelled at least 24 hours in advance, business days – Monday through Friday; for cancellations with less than 24 hours' notice, the full fee will be charged. For missed appointments with no notice given, the full fee will be charged.
- Your signature indicates you understand that you, not an insurance company or any other 3rd-party payer, will be paying for any missed or late cancelled appointments.
- Your credit card number will be kept on file throughout treatment and will be charged each time an appointment is missed without at least 24 hours advance notice. You can always call our office (24-hours a day) to leave a voicemail to cancel an appointment. However, please ensure that you cancel any appointments within the proper time frame to avoid credit card charges for missed appointments. Please know that we adhere strictly to the time requirements and Payment Agreement.
- Payments or co-payments are expected at the time of service or in advance of service. Your signature indicates you understand that if you do not pay with cash or check at the time of service (including phone or email consultation), your credit card will be charged for your payment due.
- Your signature indicates you understand you will be charged for all phone calls and email communication/consultation as indicated below, other than routine appointment scheduling, cancellation phone calls, questions regarding billing, or other administrative communications. If you do not wish to pay for such services, please schedule an appointment to instead come in and discuss your concerns. We will provide emergency services for current clients whenever possible.
- Your signature indicates you understand that your credit card may be charged for any fees or charges that your insurance company does not pay.

Payment Agreement

Current Fees for Services:

Service	Fee
Initial Assessment/Evaluation – 50 minutes	$125.00
Individual Therapy – 50 minutes (regular session)	$125.00
Individual Therapy – 100 minutes	$250.00
Marital/Couples/Family Therapy – 100 minutes	$250.00

I understand and agree to comply with this Payment Agreement. I authorize the use of my credit card information for payment of services rendered.

Client/Guardian:_______________________________
Sign:__________________________Date:__________
Print Name Signature
Client Name:__________________________________

SS# (or Insurance ID#):_________________________
If Different Than Above

Day Phone:__________________ Evening Phone:__________________
Cell Phone:____________________

Please enter the following information exactly as it appears on your credit card statement:

Please Circle: VISA / MASTERCARD AMEX Card Number:_____________________________________

Expiration:_____________ Card Verification Number:____________ Billing Zip Code:__________________

Address:____

****Your credit card information will be held confidential and this information will be secured in your client file.***