Heartstrings Counseling
Healing Hearts, Healing Families

14400 W. Burnsville Parkway | Burnsville, MN 55306
PH 612.618.1579 | FX 651.925.0415

INFORMED CONSENT

Client's Informed Consent Statement

What to Expect From Counseling

Rachel Felch, M.A., L.P.C.C, is a Licensed Professional Clinical Counselor in the State of Minnesota. She provides services through Heartstrings Counseling, P.L.C.C.

Counseling is an individually, tailored process which is designed to assist you in dealing with your concerns, coming to a greater understanding of yourself, and using effective means of coping which utilizes personal and interpersonal resources. The counseling relationship usually involves sharing personal information with your counselor, which may at times be sensitive, very private, or even distressing. Therefore, it is not uncommon during the course of counseling to feel somewhat more anxious or upset for a time. If you should feel this way, it is important to share this information with your counselor. While the outcome of counseling is often most positive, the degree to which any particular individual will reach their goals or achieve their desired level of satisfaction is not predictable. At your intake appointment, you and your counselor will review the concerns you came in to discuss, and will consider these in light of your personal history and life experiences.

You and your counselor will work out an agreement in the first or second session regarding the goals of your work and approximate time frame. Your counselor may suggest a specific number of sessions to begin with, and then reassess as the work is progressing. Your counselor may also consider referring you to another resource, if that may better meet your needs. If you have any questions, please ask. It is important that you feel comfortable about what you do with us here. Although we will make treatment recommendations, and we will try to be as clear as possible in explaining our recommendations, we want to emphasize that, unless it is an emergency, the decision about whether to proceed or not is completely yours.

Please feel welcome to give us feedback on your experience here. We want it to be as helpful and positive as possible.

Unattended children:

_____We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safety if left unattended. For the safety and welfare of the children and out of consideration for others, please make arrangements for childcare during therapy sessions, or provide adult supervision for children while waiting in the waiting room. Parents will be held responsible for any property damage caused by their child.

Minor Therapy:

_____ If you are a minor, you have a limited right to privacy in that your parents may have access to your records. Minor clients have rights to complete confidentiality in obtaining counseling for pregnancy and associated conditions, sexually transmitted diseases, and information about drug and alcohol abuse. However, if the therapist believes that sharing this information will be harmful to you, confidentiality will be maintained to the limits of the law.

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_____ If I decide to terminate therapy on behalf of a minor, I agree to discuss this with the child's therapist during a regular therapy session; not by phone. I agree to make the appropriate arrangements for a suitable termination session between the therapist and the child or children.

Missed appointments:

_____I am financially responsible for my attendance at all scheduled appointments, unless cancelled with at least 24 hour notice. The cost for a missed appointment is $75.00.

Primary Care Physician Release

_____I request that Heartstrings Counseling, P.L.C.C., to release my information to my Primary Care Physician. If so, please completed the included Release of information form.

Name of Physician/Clinic _____ Address of clinic _____

_____I do not want Heartstrings Counseling, P.L.C.C., to release my info to my Primary Care Physician at this time.

_____I do not have a Primary Care Physician

Limits to Confidentiality

The law protects the confidentiality of all communication between you and your therapist. Information can only be released to others with your written permission. No disclosure can be made, with the following exceptions:

** if you have Abused/Neglected or are abusing/ neglected a child or adult, or are being abused yourself

** if you are a danger to yourself

** if you threaten to harm to another person or persons

** if you assert that your mental condition is an issue in a claim or defense as part of a civil or criminal law proceedings

** if you report sexual exploitation by therapist

** if a court of law subpoenas/ orders your records, treatment summary or testimony by your therapist. In proceeding to assist you with entering the hospital for emotional and/or Chemical dependency treatment when you and/or your therapist , in the course of diagnosis or treatment determined that

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you're in need of hospitalization.

I have read and understand the limits to confidentiality and have discussed this information with my therapist, if requested,

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____