Mindock Counseling and Consulting
Peoria, Illinois 61615

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

ABOUT MY THERAPIST: My name is Sharon Mindock, and I am the counselor you will be seeing today. My office address is 2000 W. Pioneer Parkway, Peoria, IL and my phone number is 309-696-4697. Today's appointment will take about 45 – 50 minutes. I know that starting counseling is a big decision, and you may have many questions. I will do my best to answer any questions or concerns. This form explains information about me, my policies, State and Federal Laws and your rights about counseling. My formal education includes a Bachelor of Science Degree in Consumer and Family Science and a Masters Degree in Counseling from Western Illinois University. I am licensed by the State of Illinois as a Licensed Clinical Professional Counselor and have been helping people for over 25 years. In counseling, I talk with people about how sometimes their past experiences have an impact on how they live today, and how their thinking influences their choices. This treatment approach is called cognitive behavioral therapy. Other counseling approaches can be used depending on the person or condition. Counseling practices, philosophy and other interventions and risks will be discussed with you today.

The goal of Mindock Counseling and Consulting is to provide the most effective therapeutic experience available to you. If you and I decide that other services would be more appropriate, I will assist you in finding a provider to meet your needs.

CLIENT/THERAPIST RELATIONSHIP: You and I will have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor are any sort of trade of service for service.

AVAILABLE SERVICES: Mindock Counseling and Consulting offers a wide array of counseling services, including individual, family, couples, and group services. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is my intent to convey the policies and procedures used in my practice, and I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your therapist. If you must cancel or reschedule my appointment, I ask that you call my office at 309-402-0666 at least 24 hours in advance, whenever possible. This will free my appointment time for another client

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st visit)	$ 120
	Regular Office Visits (50 minutes) (Individuals, Couples & Play Therapy)	$ 100 - $120
	Family Sessions (90 minutes)	$ 125
	Returned check fee per check	$ 25

A reasonable fee will be charged for copies of any records requested by the Client.
PAYMENT/INSURANCE FILING: Payment of fees is expected at the time of service. I agree to let Mindock Counseling and Consulting bill my insurance company. _____(initials) date;_____
I understand that I am responsible for any payment due after my insurance pays Mindock Counseling and Consulting. Any charges that are not paid within a timely manner (30-60 days after invoice) may be turned over to a collection agency

to process. Mindock Counseling and Consulting will work with you on a payment plan to pay overdue charges. If you miss an appointment without notifying the office 24 hours in advance (exceptions such as illness will be considered) I am aware that a portion of the counseling fee will be my responsibility._____(initials)

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact my office regarding the nature and urgency of the circumstances. Email, text and other social networking sites are not confidential, and I may not be able to respond. I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: Mindock Counseling and Consulting follows all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of my counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you, and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

Signature: (initials)_____ Date:_____

CO-ORDINATION OF TREAMENT: It is important that all health care providers work together. As such, I would like your permission to communicate with your family Doctor and/or Psychiatrist. Your permission is good for one year. If you don't want me to communicate with your Doctor, it is okay and no information will be shared. Please check the correct box below.

____You may communicate with my Doctors(s)
____You may not communicate with My Doctor(s)

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

You have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.

Signature_____Date_____

Parent/Guardian Signature:_____Date_____

Cancellations: You are asked to make every effort to cancel your appointment 24 hours in advance. If this is not done, half of the assessed fee will be billed to you. In the event of illness or other emergencies, this will be waived. _____(initials).

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, the Therapist will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Partner/Parent Date

_____ _____

Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____