Informed Consent Agreement for Mental Health Treatment

ABOUT THE THERAPIST

I have a master's degree in Counseling Psychology from The University of Nebraska-Lincoln and am professionally licensed with the State of Nebraska as an Independently Licensed Mental Health Practitioner (LIMHP, CPC). I practice holistic, integrative counseling. When it comes to mental health therapy, the cutting-edge, most effective practitioners understand that the mind, body, and spirit are connected. I read the latest research concerning the mind, body, exercise, and nutrition and pass this information on to my clients. I help my clients address underlying biological, cognitive, nutritional, relational, and spiritual imbalances that affect mental health. In addition, I create a warm, open, and compassionate therapeutic environment, acknowledging that people have differing beliefs, values, experiences, and situations. Depending on your individual wants and needs, I offer emotional support dogs, counseling from a Christian perspective, and many other therapeutic approaches. No matter the specific approach, my goal is always to help you achieve lasting, positive change and the feeling of empowerment.

CLIENT INPUT

Developing an informed trust relationship and maintaining that relationship with you, and your family if appropriate and necessary, is crucial for successful treatment outcomes. Therefore, I believe in having treatment planning and progress discussions with you present unless it is therapeutically unwise. Your input will be obtained during the assessment process by completing a detailed survey and interview providing background and history information. You, and your family if appropriate and necessary, will also be asked to provide other collateral information and to offer input regarding strengths and needs, abilities, and preferences. I am also committed to obtaining client input as a tool to improve services to persons served and to assess client satisfaction. Your input regarding goal achievement will be obtained through direct involvement in the development of your treatment goals and assessments regarding goal outcomes. You have the right to refuse any requests or suggestions made during the course of therapy.

MUTUAL TERMINATION

Planning for transition and discharge begins by identifying the criteria for discharge in your treatment/recovery plan and working toward achieving your treatment goals. After stabilization and maintenance has been achieved, we will begin a phase out plan for services and begin preparing you for discharge. A final treatment session will be utilized to bring closure for you and me as your provider once discharge criteria have been met.

If, over time, I believe as your therapist that you are ignoring counsel, or on the other hand, you find that you disagree with my approach to the counseling process, it will be important for both of us to question whether it is best for you to remain with me as your therapist or seek help elsewhere. You have the right to terminate counseling services at any time. If a decision is made to terminate therapy I ask that it be a mutual decision, between yourself and me as your therapist, and that you commit to one final appointment to bring closure. One reason I ask for a final session is to safeguard against the premature termination that can result from a desire to escape when difficult issues arise.

CONSULTATION

I consult as needed and I have the right to consult concerning your case to ensure the highest quality of care possible and to provide for emergency situations. I am not bound to provide services if you refuse to do so.

_____ Yes, you may disclose healthcare information under these conditions.
_____ No, I refuse to grant consent for such disclosures.

FINANCIAL POLICIES

Payment is to be made **in full** before each session unless another source is covering your fee. Advanced payments can be made to maximize therapy time. Testing services and educational material, if applicable, are in addition to the regular fee.

Checks made out to Chapters Counseling or exact cash are accepted. Fee for bounced checks is $30 and all further payments must be made by cash.

INSURANCE

Insurance is accepted from a wide range of insurance companies. Please inquire regarding your insurance company and be ready to present your insurance card.

CANCELLING APPOINTMENTS

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last for 45 minutes. If you are late, we will end on time and not run over into the next person's session. I must receive notice of a cancellation **at least 24 hours prior** to the scheduled time. Late notice cancellations and missed appointments will be charged the full session fee, which must be paid before the next session. If cancellations and/or missed appointments become a pattern, I have the right to terminate counseling services with you.

I understand I will be charged for late notice and missed appointments and that the therapist has the right to terminate services if cancelations and/or missed appointments become a pattern. _____ (Initial)

PHONE CALLS

You are welcome to use phone calls to schedule or cancel appointments, but they are not to be used as a substitute for counseling. Calls lasting 15 minutes or longer will be billed to the client at the standard session rate. Messages will be answered as soon as possible.

EMAILING &TEXTING

For scheduling appointments, the use of texting and emailing is acceptable; however it is not to be used as a form of counseling. Due to the inherent risks and limitations of electronic communication, confidentiality cannot be guaranteed. Therefore, please limit content to non-sensitive information.

I understand the limits of confidentiality when using texting & email. _____ (Initial)

CONFIDENTIALITY

Confidentiality of the counseling provided by Chapters Counseling is protected by law; I will not notify anyone that you are receiving counseling. A Release of Information must be received from the client to disclose information. If applicable, would you like to give permission for Chapters Counseling to notify the referring physician or pastor that you are in counseling?

_____ Yes, you may notify _____ that I am receiving counseling.
_____ No, I refuse such consent at this time.
_____ Not Applicable

According to the laws of the state of Nebraska and the United States of America, confidentiality may be broken if:

1. You pose or someone connected to you may potentially pose a serious threat to yourself or another person
2. You disclose that you or another person has physically or sexually abused a child or an incompetent, disabled, or elderly person.
3. You disclose that a child or an incompetent, disabled, or elderly person is suffering because of neglect
4. There is a court order compelling me to release information
5. A non-custodial parent who wants to learn about their child's treatment may have the right to review the treatment records of the child, and/or discuss the child with me as his/her therapist.

I am required to report abuse or neglect to an appropriate government agency if that abuse or neglect is disclosed under the conditions given above.

I understand the legal limits of confidentiality _____ (Initial)

EMERGENCY/CRISIS SITUATIONS

If you have an emergency situation outside of business hours, you may call the Lancaster County Crisis hotline: 402-475-6695 or go to Bryan West Hospital at 2300 S. 16th St., Lincoln, Nebraska.

CLIENT RESPONSIBILITIES

As a client of Chapters Counseling, you have the responsibility to:

- Keep appointments or cancel at least 24 hours in advance.
- Arrive on time for appointments.
- Pay my fee promptly before each session unless another source is covering your fee.
- Notify Carolyn in case of a change of address or telephone number.
- Address issues or concerns by speaking with Carolyn.

FINANCIAL AGREEMENT/AUTHORIZATION FOR TREATMENT

I authorize treatment for the person named below and agree to pay all fees and charges for such treatment. I agree that all charges for myself/members of my family will be paid promptly unless other arrangements are agreed upon in writing.

I have read this entire Client Agreement, and I understand the conditions as stated and agree to contract for counseling under these conditions. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions.

_____ _____

Print name of client Print name of legal guardian (as appropriate)

_____ _____

Signature of client Signature of legal guardian (as appropriate)

_____

Signature of Witness

_____

Date