James J. Reed, LCPC, NCC

CONFIDENTIALITY & INFORMED CONSENT

Please read the following important information.

Eligibility for Service
James J. Reed, LCPC, NCC provides therapy services without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, or sexual orientation.

Provider Licensure
I am licensed by the Board of Behavioral Health in the state of Montana. I have a master's degree in Clinical Mental Health Therapy. I am not licensed to practice medicine, perform surgery, or prescribe drugs.

Confidentiality/Duty to Warn
While the information you provide within the therapy session is kept in strictest confidence, the following exceptions apply:

- You may sign a written authorization to share specific information with another party.
- Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful to the unborn child.
- In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.
- Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate professional misconduct.
- Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- If your therapist believes that you pose a serious, imminent and foreseeable threat to yourself or others, he/she is obligated morally and ethically to do what is necessary to prevent you from causing harm, including warning others whom you might harm.

James J. Reed, LCPC, NCC may also be court ordered to release specific records to the courts or other legal authorities. If it becomes necessary to disclose confidential information every attempt will be made to advise you beforehand and to disclose only what is necessary and relevant.

Please discuss with us any concerns you may have regarding the limits of confidentiality.

Informed Consent
Persons entering into therapy may experience emotional strains and stresses as a result of the therapeutic process. Changes create new challenges that are often the key to positive growth. This growth occurs as individuals modify emotions, attitudes, and behaviors that begin to impact significant areas of their lives.

The therapy that I am proposing and recommending for you is based on best practices to achieve the desired outcomes of your treatment plan. We will discuss the possible positive outcomes or unintended risks of the treatment modality we agree to utilize.

I cannot make any guarantee that the therapy that I propose to address your mental condition and behaviors will actually improve your mental health, change your thought processes, or modify your behaviors.

Some mental illnesses may have a medical or biological origin. I am not a medical doctor and I am not qualified to determine if a mental illness has a medical or biological origin. You should consult with a physician to determine the origin of any diagnosed mental illness that you may have.

I am proposing and recommending that I provide you with, and that you actively participate in, the following services when we determine that your mental health status indicates which of these services is appropriate:

Assessment services and evaluations, Individual therapy services, Group therapy services, Family therapy services, and Medication with prescription drugs, if recommended by a psychiatrist or physician, to address specific behaviors and conditions that you are experiencing or exhibiting.

The therapeutic relationship is a cooperative one. You have the right to fully participate in establishing and modifying, as necessary, a treatment plan throughout the course of therapy. If you ever have any questions or concerns, please let us know as soon as possible in order that they may be addressed.

Client Endorsement and Consent for Service
I ask that clients or their legal representative sign the following general consent to treatment. You may, at any time, decline specific recommendations.

- I consent to James J. Reed, LCPC, NCC providing services for myself or my legal child/dependent to include: Assessment services and evaluations, Individual therapy services, Group therapy services, Family therapy services, and Medication with prescription drugs, if recommended by a psychiatrist or physician, and involvement in the treatment planning process.
- I understand that I may request referral to another provider if I have concerns about my treatment.
- I understand that the counseling relationship is a cooperative one. I agree to give complete and accurate information as it becomes relevant. I waive any liability or responsibility on the part of the counselor when incomplete or inaccurate information has been given. I understand that counseling may introduce new stresses in my life.
- I understand that my therapist cannot guarantee 24 hour availability. However, in the event of a crisis or emergency, I can contact the on-call therapist or call 911 or go to an emergency room or some other appropriate crisis or emergency service. Once the criss is sufficiently managed, I may then contact my counselor to address pressing concerns or issues.
- I agree to discuss the termination with my therapist when I am ready to discontinue counseling.
- I have read and understand all of the disclosures listed above.
- I have been given a chance to ask any questions I had about any of the disclosures that I did not understand, that I had questions about, or that I wanted explained to me. I received answers to all of my questions.
- No one has guaranteed to me that James J. Reed's (LCPC, NCC) proposed and recommended services will improve my physical or mental health.

MEMBER RIGHTS AND RESPONSIBILITIES
All New Members/Clients will review the below rights and responsibilities and receive a copy of these Rights and Responsibilities. (The original will be placed in the members/clients chart.)

Member Rights:
- Dignity and Privacy. Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options. Each Member is guaranteed the right to receive information on medically necessary available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- Participate in decisions. Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment. Members can also request a second opinion from a provider.
- Free from restraint or seclusion. Each Member is guaranteed the right to be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Copy of medical records. Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request they be amended or corrected as specified in 45 CFR part 164.
- Free exercise of rights. Each Member is free to exercise his or her rights, and that they exercise of those rights does not adversely affect the way the Member is treated.

Members have the additional rights and responsibilities:
- To choose his/her provider.
- To ask for a therapist who understands his/her language and culture.

- To receive needed services at convenient times and places.
- To obtain access to services within the specified access standards.
- To treat others with consideration and respect.
- To be at appointments on time.
- To call if he/she must cancel.
- To be a part of the treatment team by telling your doctor or therapist about symptoms and to ask questions.
- To tell the doctor or therapist if you do not agree with recommendations.
- To tell the doctor or therapist when/if you want to end treatment.
- Take medication as prescribed and to tell the doctor if there is a problem.
- To carry his/her insurance cards.
- To tell the Provider if they have other insurance.
- To follow plans and instructions for care that they hae agreed on with providers.
- To request a second opinion.

CONSENT AND AUTHORIZATION FOR MEDICAL CARE/TREATMENT

I do voluntarily consent to the care and treatment of the above named client. I consent to the evaluation and treatment recommended by James J. Reed, LCPC, NCC, therapist. I acknowledge that no guarantees have been made to me as to the results of evaluation and treatment.

I authorize James J. Reed, LCPC, NCC, to furnish requested information or excerpts from the client's record to any insurance company, health plan or sponsoring agency who may be providing financial assistance for medical or mental health care (as well as any agents or review agencies necessary for processing any claim), including Medicare and Medicaid, for the purpose of obtaining payment; and to any physician, hospital, laboratory, radiological facility or other health care provider from which the client has been referred or to which the client is being referred as is necessary to support continuity of care. I understand that these medical records may include all information relative to the client's physical condition, past and present, including the diagnosis and history of the clients' case, psychiatric history and alcohol or drug abuse information. I understand the way James J. Reed, LCPC, NCCmay use this information as described under the Notice of Privacy Practices for James J. Reed, LCPC, NCC, of which I have received and may request an additional copy at any time.

I authorize payment of medical benefits to James J. Reed, LCPC, NCC, for services provided to the client. I also authorize payment of government benefits to James J. Reed, LCPC, NCC.

I accept full financial responsibility for services received by the client which are not covered by government benefits or any time of insurance. I understand that possession of medical insurance does not relieve me of financial responsibility to James J. Reed, LCPC, NCC at the time of services. I also understand that I am responsible for obtaining all referrals or authorizations required by my insurance.

I HAVE READ AND UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT

Signature of Client _____ Date _____ .