CONSENT TO TREATMENT

CLIENT/THERAPIST RELATIONSHIP: You and your therapist 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. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

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

RISKS AND BENEFITS: Counseling is 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. However, 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. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals in counseling.

COUNSELING: Your first visit will be an assessment session in which you and the therapist will determine your concerns, and if both agree that the therapist can meet the therapeutic needs, an initial treatment plan will be developed. Should you choose not to follow the plan of treatment provided to you, services to you may be terminated.

Our goal is to provide the most effective therapeutic experience available to you. If at any time you feel that you and the therapist are not a good fit, please discuss this matter with your therapist to determine if referring you to a more suitable therapist is right for you. If you and your therapist decide that other services would be more appropriate, they will assist you in finding a provider to meet your needs.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 45/60 minutes long. As therapy moves along less frequent visits may be suffice. If you must cancel or reschedule your appointment, we ask that you call your therapist or email at least 24 hours in advance, whenever possible. This will free your appointment time for another client. Your therapist reserves the right to charge for late-canceled or no show appointments.

OUT-OF-POCKET FEE SCHEDULE:

Assessment	$125.00
Individual 45/60 min. session	$110.00 (Duration depends on what is allowed by client's health insurance.)
Family 60 minute session	$110.00
Group 90 minute session	$ 40.00
Reports and Summary of Notes	$110.00 per/hour
Copies .	$.15/copy
Returned Check fee	$25.00

No Show/Late Cancelled Appointments: Your therapist has the discretion to charge up to the total amount of the session.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, we will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements.

If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. I hereby authorize the release of necessary medical information for insurance reimbursement purposes, and authorize payment of medical benefits to Southeast Child & Family Guidance.

COURT RELATED SERVICES: Southeast Child & Family Guidance does **not** provide court ordered treatment or evaluations, testify in court, or write reports for court or legal use. If you are seeking psychological services because of a court case in which you are involved, you most likely will be referred to other provider resources. If Southeast Child & Family Guidance is compelled to be involved in court proceedings in any way (testimony, report writing, sending copies of records, communication with attorneys, etc.) you will be charged for all time spent on such activities at the rate of **$300 per hour**. Insurance does not reimburse for those services, therefore those fees would be out of pocket expenses for the client.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact your therapist regarding the nature and urgency of the circumstances. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, your therapist 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. When we are out of town, and you and your therapist deem necessary, you will be advised and given the name of an on-call therapist.

CLINICAL CONSULTATION: The therapists participate in weekly clinical consultation meetings. During these meetings, therapists may discuss best treatment approaches for various clients. To the extent possible, the case presentations will provide no identifiable client information.

CONFIDENTIALITY: The therapists follow all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling sessions. 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 except by court order. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; concern of self-harm or harm to another person. If you have any questions regarding confidentiality, you should bring them to the attention of your therapist to discuss this matter further. By signing this form you are giving permission to your therapist and Southeast Child & Family Guidance to share confidential information with the insurance carrier responsible for providing your mental health care services and payment for those services, if the therapist is court ordered, in-house peer review, or due to the above exceptions, and you are also releasing and holding harmless the undersigned therapist and Southeast Child & Family Guidance from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person in addition to any medical or law enforcement personnel deemed appropriate:

_____ _____

Name Telephone Number

CONSENT TO TREATMENT: I acknowledge that I have read, understand, and agree to Southeast Child & Family Guidance's terms and conditions contained in this form.

_____

Client Name (PRINT)

_____ _____

Client/Parent (SIGNATURE) Date

_____ _____

Therapist (SIGNATURE) Date