Informed Consent for Counseling Services as provided by Healing Relationships, LLC

 You need to be aware of your rights as a client and give your informed consent to treatment. Your signature below indicates that you have been explained treatment alternatives, you wish to receive services from Healing Relationships, that you have received, reviewed, can request a copy of any policy at any time, understand, and you agree with the following:

1. The Client Rights Statements
2. The therapist will discuss the treatment recommendations, benefits and side effects of in-person and telehealth services
3. The Grievance Procedure
4. How to access emergency services the clinic is closed
5. Fee schedule and payment arrangements

You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my approach and methods to you. If I see a child under the age of consent (16), all custodial parents have a right to information shared in session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the child and therapist.

You have the right to decide not to receive therapeutic assistance from me; if you wish, I will provide you with the names of other qualified professionals whose services you might prefer at a cost equal to or less than my own usual customary fee.

You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision without consulting with me.

One of the most important rights involves confidentiality: Within limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is being seen in therapy, the therapist views the family as a whole as the client. Therefore, releases of information for family sessions require written approval of every consenting member of the family who was present at any time during the treatment.

If you request it, any part of your record in the files can be released to any person or agency you designate. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.

You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows:

* if you threaten grave or bodily harm or death to another person, I am required by law to call the authorities;
* if a court of law issues legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order;
* if you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority;
* if you are in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; and
* If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different).

Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a great understanding of family and personal goals and values; that may lead to a greater maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits; however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

Sessions can be carried out in person, phone, or video chat. While in-person sessions are preferable, there may be times when other means are necessary. The interactive technologies used in telebehavioral health incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Your therapist will work with you on developing a specific treatment plan that is regularly reviewed with you which includes; presenting problem(s), measurable treatment goals, treatment approaches, and an estimated length of treatment that will be updated as treatment progresses.

The clinic’s emergency policy to obtain services during periods outside of the normal operating hours has been discussed and appropriate phone numbers have been given to me. I have also been made aware of Healing Relationships grievance procedure.

***A 24 hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I understand that if it becomes a pattern of cancellations, that Healing Relationships will refer me to another therapist.***

* I understand that I can leave therapy at any time and that I have no moral, legal, or financial obligation to complete the maximum number of sessions listed in this contract; I am contracting only to pay for completed therapy sessions.
* I understand that I will be responsible for payment in full.
* I have had time to study the information and to ask any questions that I may have concerning the proposed treatment/services.
* I have also received a copy of my client rights, as well as duplicate copies of both documents for my own use.

This form is effective for 12 months after the date it was signed. After-hours emergency only crisis phone number is 920-386-3500.

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Client(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_