SAMPLE ONLY – ALWAYS FOLLOW YOUR STATE'S REQUIREMENTS and CONSIDER A SEPARATE CONSENT DOCUMENT IF THE TYPE OF COUNSELING YOU PROVIDE NEEDS FURTHER EXPLANATION.

NAME_____, DEGREES _____
_____(NAME STATE) State Licensed _____ # _____
ADDRESS_____

I completed my Master _____ degree in _____ at _____ (University/College). I have worked in the mental health field since _____ and have been a licensed _____ counselor since _____. I have provided psychotherapy to _____ (EX: People of all ages, backgrounds…) in a (OPTIONS: SPECIALTY or VARIETY) of treatment in an OPTIONS: IN-PATIENT, OUT-PATIENT, BOTH) setting. I have additional training in _____, working with (OPTIONS: FAMILIES AND COUPLES, PARENTING ISSUES, SELF-ESTEEM, GRIEF AND LOSS, PSYCHOLOGICAL TRAUMA, MOOD DISORDERS, ADHD, AND ANXIETY DISORDERS). The approaches I generally use include (OPTIONS: COGNITIVE- BEHAVIORAL THERAPY, AND FAMILY SYSTEMS) models. Typically, therapy begins with an assessment that identifies your unique needs as well as your strengths and resources.

Risks and Benefits: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will discuss personal issues which may bring up emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course, but it is my goal is to create a safe environment where together we develop a treatment plan, and work to achieve your goals.

Confidentiality and Your Rights: Your treatment is confidential. Information you share with me may be entered into your records in written form. I am providing you with a copy of my Privacy Practices Notice which gives more detail about your rights to confidentiality. In most circumstances, information in your records can be released only if you specifically authorize it in writing. The following list tells you when confidential information may be released to others without your consent:

1) I am required by law to report information about child abuse/neglect or elder abuse/neglect.

2) If you threaten to harm yourself or someone else, and I believe your threat to be serious, I am required by law to take whatever actions necessary to protect you or others from harm.

3) If you are involved in litigations of any kind and inform the court of the services you received from me (making your mental health an issue before the court), you may be waiving your right to keep my records confidential. I may disclose your health information if a court issues an appropriate order. Please consult your attorney for clarification.

Licensed counselors follow _____State law, Department of Health rules, as well as the Codes of Ethics of their professional organizations. The purpose of the rules and laws is the protection of the public by ensuring the competence of counselors and by providing a complaint process against those counselors who commit acts of unprofessional conduct. As a client you have the right to choose a counselor and the type of treatment that best suits your needs. You also have the right to refuse treatment at any time. I am providing you with a copy of the WA State brochure "What to Expect from your Licensed Mental health Counselor", which provides general information about the laws and rules that govern counseling practices in _____ State. To contact the _____ State Department of Health for more information or to file a complaint please call _____, or visit their website at _____.

I acknowledge that the Clinician has verbalized the Limits of Confidentiality and My Rights and I have had an opportunity to seek clarification and ask questions _____(initials)

There are several reasons why the counseling relation is brought to completion, to address a few: Client is not benefiting from counseling; Client needs a higher level of care; the Counseling is, or comes to be, outside the clinician's scope of work, Client is not paying, as arranged, for the services, Client requests another counseling intervention outside the clinician's scope of work.

The client can bring counseling to completion by their own choice or the clinician can bring counseling to a conclusion based on the clinician's best clinical judgement.

Phone Calls and Emergencies

Please be aware that my office does not have a receptionist, so you will likely have to leave me a voice mail. I will make every effort to return your call within 1-2 business days if not an emergency. My office voice mail is confidential, and the messages are only heard by me. If you are experiencing a life-threatening emergency, please call 911. If you are experiencing a psychiatric emergency or crisis and I am not available, please call the **_____ County 24-hour Crisis Line at _____.**

Billing Policies Insurance/ EAP (Employee Assistance Programs)

Most, but not all medical insurance plans cover the services I provide. Please understand your insurance is a contract between you and your insurance company and that you are ultimately responsible for any unpaid balance. It is your responsibility to contact your insurance company to find out what portion of the costs are covered, how many visits are allowed, and if you have an unmet deductible.

Co-pays are expected to be paid at the time service is given. I accept checks payable to _____ or cash. If you have been referred to me through an (OPTIONS: EAP, COMMUNITY COUNSELING AGENCY, ANOTHER CLINICIAN, PHYSICIAN), you must make sure the services were authorized prior to your first visit. Depending on the plan, you may choose to continue services with me or you may request a referral to another provider. If your treatment needs are outside of the scope of my expertise, you will be referred to a provider who can better treat you.

Appointments and Fees

Your appointment, which lasts about 50 minutes, has been scheduled exclusively for you. My fees are as follows:

Initial Assessment Session .....$135.00 for 50 Minute Therapy
Sessions .....$100.00 Writing Letters/Phone Calls (outside the session)
No Show .....$50.00 No Show Fee
Less than 24-hour cancellation .....$25.00 Late Cancellation Fee

As part of your treatment, you may need me to compile/summarize the results of an assessment or treatment episode for the purposes of writing a letter on your behalf. Insurance companies do not allow me to bill them for such services, nor do they allow me to bill them for phone calls I make outside of the therapy session.

My policy is to bill you directly for these services (Summaries/Letters/Phone Calls) should you request them. Generally, I am flexible about missed appointments, however if last minute cancellations or missed appointments become a chronic problem, I will bill a missed appointment fee.

By signing this Client Information and Consent Form as the Client or Legal 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 receiving 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. I certify that I have received a copy of, or have had the opportunity to read following information:

1. My counselor's Individual Disclosure Statement, Consent, and Fee Schedule
2. If applicable, any additional fee contract RECEIVED _____ (initials)
3. Washington State's Counseling brochure
4. A copy of the Privacy Practices Notice

Authorization to Release Information for Billing Purposes

I understand that some of my personal information may be released to my insurance company or EAP, to bill them for the services. By signing below, I am consenting to the release of that information. If my insurance company or EAP refuses to pay for the services provided, I understand that I am fully responsible to pay for the services, and I agree to do so. If I refuse to pay for the services, I understand that some of my personal information may be released to a collections agency in order to collect the overdue fees.

_____ _____
Client Signature Date
PRINT NAME : _____

_____ _____
Client Signature Date
PRINT NAME : _____

If applicable, I/we acknowledge that I/we is/are the legal guardian of _____
(minor child) and have provided the appropriate court document to the clinician

_____ _____
Parent/Legal Guardian 1, Signature Date
PRINT NAME : _____

_____ _____
Parent/Legal Guardian 2, Signature Date
PRINT NAME : _____

_____ _____
Clinician Signature Date