INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name _____ Date of Birth _____

BENEFITS OF COUNSELING/THERAPY

Therapy can help a person to gain new understanding about his or her problems and to learn new ways of coping with and solving those problems such as anxiety, anger, depression, parenting or relationship concerns. Therapy can help a person to develop new skills and to change behavior patterns. Therapy can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others.

Therapy, whether individual, couple, family, or group, focuses on resources, solutions and strategies to deal with your presenting problem. While your therapist will ask about many areas of your life, the focus of therapy will be on working toward your specific goals. In order for therapy to be effective, it is necessary for you to take an active role. Participation involves discussing your concerns openly, completing assignments, and providing feedback to your therapist about the progress of therapy.

RISKS OF COUNSELING/THERAPY

I acknowledge that I have been advised that while there are potential benefits to therapy there is no guarantee of success and that potential risks also exist. I have been advised that during therapy emotions and memories may be stimulated which can evoke strong feelings and that changes in awareness may alter my self-perceptions and ways of relating to others. I have been advised that the process of personal change can be quite varied and individual.

CONFIDENTIALITY

I understand that all information shared with a clinician is confidential and that no information will be released without my written authorization. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is legally and ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

PROFESSIONAL RECORDS

The laws and standards of my profession require that records concerning treatment and progress are kept. You are entitled to receive a copy of these records at any time unless doing so could be potentially dangerous or possible negative consequences. If this is the case, records can be provided to health care providers at your request.

PROFESSIONAL FEES AND PAYMENT

The fees for services vary depending upon the service being provided. The rate for counseling is $100 per session for 1 hour, $125 for 75 minutes, $150 for 90 minutes and $200 for 2 hours.

You will be expected to pay for each session at the time it is held unless other arrangements are made or you have insurance coverage. Payment options include cash and charge. Within 60 days if your account is not paid or arrangements for payment have not been made, there is a possibility that legal means will be used to secure such payment. This may involve hiring a collection agency or going through legal proceeding which would require information about you to be released without your consent. If such action is necessary, any costs incurred will be included in the claim.

If you wish to cancel an appointment, please **do so within 24 hours of the visit**. Otherwise, the usual session fee will be charged for any missed appointment. If there are circumstances beyond your control please discuss this with the therapist.

ACKNOWLEDGEMENT AND CONSENT

If I have any questions regarding this consent form or about the services offered, I may discuss them with my therapist. I have read and understand the above information. I consent to participate in the treatment offered to me by Barbi Pecenco Kolski, LMFT. I understand that all counseling is voluntary and that I may stop therapy at any time for any reason.

_____ _____

Signature Date

_____ _____

Signature Date

Barbi Pecenco Kolski, LMFT _____

Therapist's Signature Date