Restoration Counseling and Consulting, Inc.

Informed Consent Form

Welcome to my private practice. This document contains important information about my professional services and business policies. Please read it carefully and make note of any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

COUNSELING SERVICES
The first 2 to 4 sessions will involve an evaluation of your history and your needs. By the end of this evaluation, I will offer you some initial impressions of what our work might include. We will work collaboratively to create an initial treatment plan.

Therapy involves benefits and risks. Risks may include experiencing uncomfortable feelings, such sadness, guilt, anxiety, anger, frustration, etc., because the process of therapy often requires discussion of difficult areas of your life. Relationship dynamics may change. Benefits can include a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, increased skills for managing stress, resolution to specific problems, and improvement in overall mental health. There are no guarantees about what will happen. Therapy requires active effort on your part, with work outside of session. Outcomes are dependent upon client effort and quality of the information shared with your therapist.

APPOINTMENTS
Appointments will ordinarily be 45-50 minutes in duration. Typical frequency is once per week, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is reserved especially for you. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without this notice, my policy is to collect the amount of your co-payment unless we both agree that you were unable to attend due to circumstances beyond your control. Insurance companies do not provide reimbursement for missed sessions. If you are late to your appointment, we will still need to end on time out of respect for my next client.

INSURANCE
With your written permission, I will assist you to the extent possible in filing in insurance claims for services as a courtesy. You are responsible for knowing your coverage and for letting me know if/when your coverage changes. You are also responsible to know if pre-authorization is necessary, and whether I am a covered provider under your plan. Insurance companies will require that I provide them with a clinical diagnosis for you. This diagnosis comes from a book entitled the DSM-V. I have a copy of this book in my office, and will be glad to let you see it to learn more about your diagnosis, if applicable. At times insurance companies will ask me to provide additional clinical information such as treatment plans, treatment summaries, or (rarely) copies of the entire record. This information will become part of the insurance company files, at which point I have no control over their confidentiality policies and procedures. **Your signature on this agreement indicates that you authorize me to release the necessary clinical information to your insurance carrier if you are opting to utilize insurance benefits to pay for your treatment.** ___________________________________

RECORDS
I am required to keep appropriate records of the counseling services I provide. Your records are maintained in a secure location. I keep brief records noting the dates and times you are here, your reasons for seeking therapy, the goals and progress of treatment, your diagnosis, your medical/social/treatment history, records I may receive from other providers, topics of discussion, and billing records. You have the right to a copy of your records. It is my policy that you review them with me in my office. Only with your written request, I will make a summary of all or part of your records available to the individual or agency of your choosing. Depending on the time required to prepare this information, there may be a charge involved. This will be discussed and agreed upon prior to beginning this process.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in separate documents that you will review with me and sign. Please remember that you may reopen the discussion about this issue at any time during our work together.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. I will return any phone calls within one business day. If your call is an emergency and I am not available, please dial 911 or visit your nearest local emergency room. Be advised that I cannot guarantee the confidentiality of emailed correspondence, so please use caution in sharing any personal information when contacting me through this medium. I will accept texts only related to scheduling issues. By mandate of my Code of Ethics, I am unable to accept friend requests through social media.

CLIENT RIGHTS

If you are dissatisfied with anything happening in therapy, I encourage you to talk with me so that I can respond to your concerns. You will be taken seriously, and your concerns will be handled with care and respect. You may also request a referral to another therapist at any time, and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, gender, sexual orientation, age, religion, or source of payment. You have the right to ask questions about my qualifications (including training, credentials, and experience). You have a right to expect that I will only provide services within the context of my qualifications and competencies. You have the right to expect that I will not have social or sexual relationships with current or former clients.

Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit. Ethics also require that I not provide therapy if you are currently in therapy with someone else. You must first terminate treatment with that therapist before I can begin providing services. For the safety of both of us, your session will be immediately terminated in the event of threats or violence, or if you arrive under the influence of drugs or alcohol.

Your signature below indicates you have read this agreement, that you have had the opportunity to have your questions answered regarding its contents, and that you agree to these terms. This agreement remains in effect for the duration of your treatment.

____ ________________________

Printed name of Patient or Personal Representative Date

____

Signature of Patient or Personal Representative

HIPPA

By signing below, I acknowledge that I am in receipt of Restoration Counseling and Consulting, Inc.'s HIPPA notification. My signature indicates I understand the document and my rights allowed through the Privacy Act.

____ ________________________

Printed name of Patient or Personal Representative Date

____

Signature of Patient or Personal Representative

OFFICE AGREEMENT

I understand that Restoration Counseling and Consulting, Inc., shares office space with Stacy Gorman, LLC. I understand that they are separate businesses, and therefore not liable for situations occurring during the course of each other's business practices.

____ ______________________

Printed name of Patient or Personal Representative Date

____

Signature of Patient or Personal Representative

COURT POLICY

I understand that information discussed in therapy is for therapeutic purposes and is not intended for use in any legal proceedings. I agree not to subpoena my therapist to testify for or against any party or to provide records in a court action.

____ ______________________

Printed name of Patient or Personal Representative Date

____

Signature of Patient or Personal Representative

CONSENT FOR TREATMENT OF A MINOR

I, the undersigned, hereby authorize Luanna Olthoff or Dr. Kathleen Brown-Rice, to administer treatment to this minor child as necessary. I certify that I am the parent or the legal guardian of this minor child, and that I have notified all other parents and legal guardians of my intent to seek treatment for this child. I also certify that no assurance or guarantee has been made as to the results that may be obtained.

____ ______________________

Printed name of Patient or Personal Representative Date

____

Signature of Patient or Personal Representative