**INFORMED CONSENT FOR COUNSELING SERVICES**

**Confidentiality:**

I understand that all information I disclose within sessions is confidential and not to be revealed to anyone outside Associates in Behavioral Health without my permission. The only exceptions include, but are not limited to, situations where:

1. There is alleged or suspected child abuse or neglect

2. There is evidence of danger to an individual or society

3. The counselor is subpoenaed and ordered by a judge to testify in a court of law, or as required by law

4. A legal parent or guardian of an individual under the age of 18 requests information about the child

5. For the purpose of providing the best service possible, your case may be discussed with my supervisor and/or peer supervision group, without revealing any identifying information

In the above situations, when possible, my therapist will thoroughly discuss this situation with me and obtain my consent to release information before any action takes place. In an effort to provide quality care, my therapist may confidentially consult with appropriate professional colleagues to seek greater wisdom to provide the best possible counsel.

**Risks & Benefits:**

I understand there is a possibility of risks and benefits which may occur in counseling. Counseling may involve the risk of remembering unpleasant events or arousing strong emotional feelings. Counseling can impact relationships with significant others. The benefits of counseling may be improved ability to relate with others, a clearer understanding of self, increased academic/job performance, and better ability to cope with daily stressors. Taking responsibility for working with these issues may lead to greater growth.

**Appointments:**

Individual sessions are 45‐50 minutes long. If the therapist is late to an appointment, the complete time will be allowed. However, if the client is late, the appointment will end at the scheduled time. It is usually recommended that sessions begin weekly; however, we will schedule appointments according to your specific needs. You are responsible for paying any co-payments, deductibles, or non-covered services at the time service is rendered.

 **Insurance:**

It is **your responsibility** to provide us with the correct information regarding your insurance company and to follow the rules of your insurance company. You must comply with such rules as; a valid referral form and precertification in order for your claims to be paid. We will assist you however, if claims are denied because of your failure to comply with the above, you will be financially responsible for paying denied services. Unless payment arrangements are made and kept, accounts that are outstanding for more than 90 days may be sent to our collection agency. In the event your account is turned over to a collection agency, you are held responsible for any and all related attorney and/or collection fees.

**Calls & Emergencies:**

After hours, clients with emergencies are encouraged to call Life Crisis at 314.647.4357, Behavioral Health Response at 314.469.6644, or go to the nearest emergency room.

**Cancellations and No Shows:**

Our policy requires that an appointment be cancelled 24 hours in advance. If a client does not show for a scheduled appointment or fails to provide 24 hour notice for a cancellation, they will be charged **$ 45.00.**

**Termination:**

If after a period of time it becomes clear that I am not benefiting from counseling, my therapist will provide me with one or more referral that may better fit my needs. I understand that I am free to leave counseling at any time. If I choose to terminate counseling prior to the expected termination date, I commit to discuss this decision with my therapist in advance of my actual termination. I have read the above information and understand what I can expect from counseling. I give my consent to enter in a counseling relationship with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I agree that if any dispute arises with anyone employed by Associates in Behavioral Health from or related to this agreement, this dispute shall be settled by mediation.

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Client/Guardian Signature Date

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Therapist Signature Date

I HAVE DISCUSSED THIS INFORMATION WITH MY CLIENT