INFORMED CONSENT

The following document is an agreement to enter into a CONSULTATION TREATMENT PROCESS. The purpose of this process is:

1) To affirm the fit between Testimony Life Resources and you as the client.
2) To determine an appropriate therapist for you.

During the consultation process both you and your therapist can mutually agree to decide to move into psychotherapy treatment together.

TESTIMONY LIFE RESOURCES is a non-profit counseling center. HIPAA requires that we provide you with a *Notice of Privacy Practices* (the Notice) for use and disclosure of your personal health information for treatment, payment, and health care options. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of your first session.

APPOINTMENTS: Your appointment time is reserved for you. Appointments are typically held once per week for about 50 minutes at a time. We can reserve regular appointment times for you every week, but it is your responsibility to notify your therapist at least 48 hours in advance if you are unable to attend your appointment. **Cancellations of appointments less than 48 hours in advance and "no shows" are subject to the full fee for the appointment time. Your insurance will not cover this charge.**

PAYMENTS AND FEES: Full payment is expected at the time of services unless other arrangements have been made. Fees vary for clients depending on the individual services that each client receives. We will provide you with receipt that includes the necessary information for you to seek reimbursement from your insurance company. Credit cards, check and cash are all accepted forms of payment. You may also incur charges for phone calls lasting more than 15 minutes, letters and testing fees. There is a $20.00 charge for returned checks.

I, the client, agree to be responsible for the payment of $_____per session (50 minutes) which is payable at the time of the session. I understand that I am responsible for payment, even though I may be reimbursed by my insurance company. Client Initials _____

PHONE MESSAGES AND PHONE SESSIONS: In some cases, you, as the client, may find it necessary to have a phone session in order to deal with a situation or issue. If this is the case, your therapist will have a phone session with you at the agreed upon fee. If your therapist does not have the time available, or does not feel that a phone session is necessary or appropriate, then a scheduled session will be made available for you as soon as possible. If you leave a message for your therapist, he/she will call you back as soon as possible. However, it may not be until the next business day.

EMERGENCIES OUTSIDE SCHEDULE SESSIONS: In the case of a life-threatening emergency, please dial 911 for assistance. Your therapist is not always available for an immediate response, but will return all phone calls within 24 hours. Please contact your primary care physician, local hospital, or police department in the event of other emergencies outside of schedule sessions.

LIMITS ON CONFIDENTIALITY: There are some situation in which a therapist is legally obligated to take actions that he/she believes are necessary to attempt to protect client or others from harm, and he/she may be required to reveal limited information about a client's treatment.

- **CHILD ABUSE:**
  If your therapist has knowledge of **or reasonably suspects a child under 18 has been the victim of child abuse or neglect**, the law requires that your therapist file a report with the appropriate government agency. This can include when your therapist reasonably suspects that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way. It can also include some sexual activity i.e. oral sex among minors under certain conditions. If you have any questions please clarify this with your therapist. Once such a report is filed, your therapist may be required to provide additional information.
- **DANGER TO SELF:**
  If your therapist has **reasonable cause to believe that the client is in such mental or emotional condition as to be dangerous to himself or herself**, your therapist may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.
- **THREAT OF VIOLENCE TO OTHERS:**
  If a client communicates a serious threat of physical violence against an identifiable victim, your therapist must take protective actions, including notifying the potential victim and contacting the police. Your therapist may also seek hospitalization of the client or contact others who can assist in protecting the victim.
- **ELDER/DEPENDENT ADULT ABUSE:**
  If your therapist observes or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult -- or if an elder or dependent adult credibly reports that he/she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse -the law requires that your therapist report to the appropriate government agencies. Once such a report is filed, your therapist may be required to provide additional information. **If such a situation arises, your therapist will limit disclosures to what is necessary.**

PRIVACY: The law protects the privacy of all communications between client and your therapist. In most situations, your therapist can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by state law and/or HIPAA. **However, there are some situations where your therapist is permitted or required to disclose information without either your consent or authorization.**

PARENTS AND NON-EMANCIPATED MINOR CLIENTS under 18 years of age can consent to psychological services subject to the involvement of their parents or guardian.

- Unless your therapist determines that parental involvement would be inappropriate.
- A client over 12 years of age may independently consent to psychological services if he/she is mature enough to participate intelligently in such services, and the minor client either would present a danger of serious physical or mental harm to himself/herself or others, or is the alleged victim of incest or child abuse.
- In addition, clients over 12 years of age may independently consent to alcohol and drug treatment in some circumstances.
- However, non-emancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless your therapist determines that access would have a detrimental effect on the professional relationship with the client, or to his or her physical safety or psychological well-being.
- It is our policy to request an agreement with minors (over 12 years of age) and their parents about access to information. This agreement provides that during treatment, your therapist will provide parents with only general information about the progress of the treatment, and the client's attendance at scheduled sessions. Your therapist will also provide parents with a summary of their child's treatment. Any other communication will require the child's authorization, unless your therapist believes that the child is in danger or is a danger to someone else. In which case, your therapist will notify the parents of his or her concern. Before giving parents any information, your therapist will discuss the matter with the child, if possible, and try to handle any objections he/she may have.

If the following information below is completed, please note that your counseling/treatment will be with a NON-LICENSED therapist.

Non-License Therapist Declaration: (I understand that my counselor is a) …

_____MFT Trainee _____MFT Intern _____Counselor_____Pastor _____Life Coach

_____Addiction Counselor _____Doctoral Student _____Psychologist Assistant

I acknowledge that my counseling will be reviewed and supervised weekly by a licensed supervisor. I understand that the primary supervisor has full access to the treatment records in order to perform supervision responsibilities. I have also received the business card of my therapist, which lists the supervisor's information.

_____ (therapist) and members in clinical training working under the direct supervision of _____(supervisor), have my permission to view/listen to the audio/video-taped counseling sessions. I understand that my sessions will be taped only with my knowledge, will be used only for supervision purposes and will be erased as soon as this purpose is fulfilled.

Client Initials: _____

TERMINATION OF THERAPY: Your therapist will provide counsel for you regarding termination, but you must make the ultimate decision about continuing care. It is to the client's advantage that a decision to end therapy will be discussed candidly and thoroughly with your therapist in advance of leaving.

Your signature below indicates that you have read this agreement, agree to its terms and Acknowledge that you have received the HIPAA notice form described above. Please feel free to discuss any concerns you may have with your therapist as they arise. This form and a HIPAA document, comply with both state and federal requirements.

CLIENT SIGNATURE _____DATE:_____

CLIENT SIGNATURE _____DATE:_____

THERAPIST SIGNATURE_____DATE:_____