Informed Consent for Counseling Services

ANCHORED COUNSELING AND WELLNESS: CLIENT SERVICE AGREEMENT

Welcome to Anchored Counseling and Wellness. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Since therapy often involves discussing unpleasant aspects of your life, you may initially experience uncomfortable feelings like sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy may lead to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. Psychotherapy requires active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your goals. By the end of the evaluation, I will be able to offer you some first impressions of what our work might include and a suggested treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with us. If you have questions about my procedures, we should discuss them whenever they arise. If your concerns persist, I would be happy to help you set up a meeting with another mental health professional.

SESSIONS

Appointments will ordinarily be between 50 and 60 minutes. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24-hour's'notice. If you miss a session without letting me know, or cancel with less than 24-hour's notice, my policy is to charge an $85.00 cancellation fee.

PROFESSIONAL FEES

The standard fee for the initial intake is $110.00 for individuals and $140.00 for couples. A limited sliding scale may be offered and can be discussed. You are responsible for paying at the time of your session unless prior arrangements have been made. The fee for consultation with other clinicians, professionals, and or legal or medical documentation on your behalf is billed at $110.00/hour. I accept Venmo, cash, checks, and credit cards. I will ask for a credit card to keep on file for ongoing appointments.

INSURANCE

Anchored Counseling and Wellness has chosen not to work directly with insurance companies for the following reasons:

- Insurance companies require us to assign a mental health diagnosis in order to cover the cost of therapy. Many people who seek counseling are interested in learning new skills and strategies to improve their lives,

and do not necessarily have a mental health diagnosis. I prefer not to be forced to provide one when I believe none exists.
- Many insurance companies place restrictions on the types of services they cover. For example, many insurance companies do not cover marriage or family counseling.
- Insurance companies may place restrictions on the course and duration of treatment. This restricts my ability to prescribe the treatment plan I believe will be most beneficial for you.

If you would like to file for insurance reimbursement, please check your coverage for out-of-network mental health services, and I will provide statements for you to submit to your insurance company.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a counselor is protected by law and your counselor can only release information to others with your written permission. My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have now been provided with a copy of that document and we will discuss it further during your first appointment. Please remember that you may reopen the conversation at any time during our work together.

Please note the following exceptions:

1. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody, and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.
2. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.
3. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victims, contacting the police, or seeking hospitalization for the client.
4. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations rarely occur, however, it is important for you to understand your rights regarding confidentiality and related exceptions. While this written summary should prove helpful to inform you about potential problems, it is important that we discuss any questions or concerns that you may have. I will be happy to discuss these issues with you, however, you may need to obtain specialized legal advice from an attorney since the laws governing confidentiality are quite complex.

HIPAA additionally protects your confidentiality on all electronic transmissions of information about you. If you elect to communicate with your counselor by e-mail, please be aware that email is not completely confidential.
All e-mails are retained in the logs of Internet providers. While under normal circumstances, no one looks at these logs, they are, in theory, available to be accessed by the system administrator.

CONTACTING US

I am often not immediately available by telephone as I do not answer phone calls when in session with clients. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, usually within 24 hours. However, please note it may take 24-48 hours for non-urgent matters. You may email me for scheduling and follow up matters, but I do not offer in-depth, online counseling, and I cannot guarantee your confidentiality with this mode of communication. If you feel you cannot wait for a return call, or if you feel unable to keep yourself safe please:

- **Go to your local hospital emergency room**
- **Call 911 and ask to speak to the mental health worker on call**

OTHER RIGHTS

If you have concerns about what is happening in therapy, I ask that you talk with me so we can address them. Your comments and questions will be taken seriously and handled with care and respect. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about our training and experience. You may request that I refer you to another therapist, and have the right to end therapy at any time.

CONSENT TO COUNSELING

I have read this statement, had sufficient time to be sure that I considered it carefully, asked questions that I needed to, and understand it. I understand the limits to confidentiality required by law. I agree to pay the counselor's fee. I understand my rights and responsibilities as a client and my counselor's responsibilities to me. I agree to undertake counseling with Anchored Counseling & Wellness, I know I can end therapy at any time I wish, and that I can refuse any requests or suggestions made by Anchored Counseling & Wellness.

Your signature below indicates that you have read the information in this document, received a client copy and agree to abide by its terms during our professional relationship.

Signature of Client or Personal Representative:_____

Printed Name of Client or Personal Representative: _____

Date:_____

No Show and Cancellation Agreement

The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session,

Per Anchored Counseling and Wellness Client Service Agreement, I have agreed to abide by ACW's No Show and Late Cancellation Policy

CANCELLATION: If you want to cancel your appointment for any reason, please call or email our office 24 hours before your appointment. I will happily cancel your time and give it to another client with no cost to you! If you fail to do this, you will be charged $85.00. I will ask you for a credit card number to have on file when you come in for your initial session. If no card is on file we will bill this fee to your account.

EMERGENCIES: I understand that sometimes your child wakes up sick, you get in a car accident on the way to the office or some other genuine emergency can happen. If this is the case, please call and discuss this with the office ASAP (preferably before your appointment time). I will waive the cancellation fee for this event as long as it is not a pattern.

NO SHOWS: This includes forgetting your appointment or simply choosing not to come in at your scheduled time. You will be charged the $85.00 fee on your credit card kept on file. If no card is on file we will bill this fee to your account. If you arrive more than 10 minutes late for your scheduled appointment time it is also considered a "no show".

Client Name: _____

Client Signature: _____

Date: _____

Credit Card: _____

Expiration Date: _____ Security Code: _____ Zip Code: _____

Anchored Counseling and Wellness

Release of Information Consent Form

I, _____ give my permission for the following releases of information to and from my counselor at West Chester Counseling.

The Following Person/s, Agency:
Name of Agency, hospital, doctor, or therapist:
_____

Please provide contact information for above mentioned:
_____
_____
_____
_____

The items covered by this release are marked below:

Intake Assessment	_____	Treatment Plan	_____
Psychiatric Evaluation	_____	Psychological Evaluation	_____
Discharge Summary	_____	Other: _____	

This information is being released for the following reasons:
_____
_____
_____
_____

____ I understand this consent with expire 1 year from the date it is signed; however, I may revoke this authorization at any time prior.

Client Signature: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Counselor's Signature: _____ Date: _____

Anchored Counseling and Wellness

Client Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?
□ Daily. □ Weekly. □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes,

for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____