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520.203.1943

Consent for Treatment

Introduction

This consent is to acquaint you with my practice. If this is the first time you have ever been in counseling, you may have some questions and concerns. After reading this statement please feel free to discuss any questions that you may still have which were not addressed sufficiently or at all. I am a Master's level clinician in the practice of Counseling Psychology. I am licensed under the laws mandated by the Arizona Board of Behavioral Health Examiners. My formal and ongoing education as well as previous counseling experience has prepared me to counsel individuals, families, and couples in treatment for issues coping with mental health concerns, dual diagnosis, substance abuse, and addictions.

Confidentiality/Consultation

As a licensed therapist, I am committed to helping my clients in the most professional, effective and ethical manner possible. In pursuit of this commitment and for the purpose of learning and enhancing my skills as a clinician, I may seek consultation from time to time. This is for my seeking feedback about case conceptualization and treatment planning. In these cases, I am required to protect the privacy of all individuals involved and **no names of clients are ever disclosed in consultation**. However, under specific circumstances (listed below), I am required by Arizona State law and the Arizona Board of Behavioral Health Examiners to breach confidentiality. As such mandated limits of confidentiality will apply. I have read the above and understand the following.
Initials _____

Nature of Counseling and Therapy

I view my role as therapist to be a skilled and experienced clinician who works in collaboration with you to find alternative perspectives and insights to current stressors and issues in your life. The course of therapy, be it short-term or longer-term will be decided between you, the client, and myself and detailed in a treatment plan so as to make our time together productive and enduring. Psychotherapy can have benefits and risks.

Guardian Signature _____ Date _____

Client Signature_____ Date _____

Therapist Signature _____ Date _____

Nature of Counseling and Therapy cont'd.

At times, therapy can involve discussing unpleasant feelings and/or aspects of your life. In addition, as we process unresolved traumas and experiences you may experience uncomfortable feelings or a temporary worsening of your mood and/or symptoms. If I propose a specific technique that may have risks attached (e.g. Eye Movement Desensitization and Reprocessing), I will inform you of that and discuss with you the risks and benefits of my suggestions.
You have the right to decide against any therapeutic intervention at any time. I look forward to working with you as you utilize new perspectives, coping skills, and/or insights in your life. **Initials** _____

Sessions/Fee

All sessions are 50 minutes and are scheduled by appointment. At this time my fee ranges from $150 - $180 per 50 minutes. The actual fee will depend on the duration of the session and the type of appointment. At times adjunctive assessments may be necessary. We will discuss any additional fees at the time of the recommendation. After an initial session, if we agree that further visits are desired, we will work together toward developing a treatment plan that defines therapeutic goals, objectives, and after-care follow-up.

Referrals and Termination

If at any time and for any reason you are dissatisfied with my therapeutic services, I will provide alternative resources that may be better suited to meet your needs. At no time will our therapeutic relationship end without a clinically supportive referral in place. You may revoke your consent for treatment at any time. Failure to do so will result in an automatic expiration one year after our last therapy session.

Cancellation and No-Show Policy

In the event that you will not be able to keep an appointment, please call the office (emails or texts are not applicable here) **at least** 24 hours in advance **520.203.1943**. **Intensives are payable in advance and non-refundable.** I consider our clinical time together as a significant and mutually valued experience. As such, attendance to our scheduled sessions is important. If you experience an unforeseen and infrequent emergency that results in a missed session, please call as soon as possible and I will make every effort to reschedule. However, if you miss a scheduled appointment that it is not the result of an emergency **or** you do not cancel with at least 24-hours' notice, you will be assessed a cancellation fee of $150. **Initials** _____

Records and Confidentiality

Any or all of our communication may become part of the clinical record. This record remains with me and is in no way ethically or legally allowed to be viewed by others. Your therapeutic file is always available to you during our session. If, however, you have reason or need to view your file outside the therapy session, please call and make an appointment so that we may review your file together. There are several cases (as listed below) for which I may need to breach confidentiality and divulge information regarding our sessions.

Exceptions to confidentiality:

1) If I determine that you present a danger to yourself and/or others. _____
2) If you disclose to me knowledge of, or founded suspicion of ongoing child or elder abuse. At times the counselor could be subpoenaed into court to testify. _____
3) If you divulge current or past consensual or non-consensual sexual contact, sexual abuse, sexual assault or sexual exploitation of a person under the age of 18 y/o. _____
4) If you divulge past or current sexual exploitation of a person under the age of 18 y/o including knowledge of a person who knowingly downloads, streams, or accesses through any electronic, digital or print media, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct. _____
5) I am ordered by a court to disclose the information as a result of a previous and/or ongoing investigation into actions taken by you, the client. _____
6) If you disclose current and/or ongoing information regarding contact with a health professional that is in violation of their ethical and legal practices. _____
7) If you direct me to disclose information for continuity of care and sign a release of information to do so. _____

My initials above and my signature below indicate that I understand and agree with the terms set forth in this consent for treatment.

Guardian Signature _____ Date _____

Client Signature_____ Date _____

Therapist Signature _____ Date _____