

Choices Counseling and Coaching, Inc.
Counseling Services Contract
INFORMED CONSENT

Welcome to Choices Counseling and Coaching. This document contains important information about our professional services and business policies. We ask that you read it carefully and sign it as an acknowledgement of your agreement to abide by these policies.

Counseling Services

Counseling and Coaching is not easy to describe. It involves a special relationship between the therapist and client and the particular problems to be addressed. There are a number of different approaches that can be used in this process. The counseling process requires an active effort on your part. Hopefully you will take the things we discuss and work on them between our sessions

Counseling has both benefits and risks. It is risky to reveal yourself to your counselor and that revelation may evoke uncomfortable feelings. The benefits to the risk taking may be a clearer understanding of the issues and adoption of a new perspective.

Appointments

Appointments are usually scheduled for 50 – 60 minute sessions. Once this appointment is scheduled, you will be expected to pay for it, unless you provide 24 hours advance notice of cancellation.

Insurance Reimbursement

If you have a health insurance policy, it may provide some coverage for mental health treatment. Our office will provide you with whatever assistance it can to facilitate your receipt of the benefits for which you are entitled to, including filling out forms as appropriate. *You are ultimately responsible for full payment of the fee regardless of whether or not your insurance company has properly or improperly determined payment.*

Managed Health Care Plans often require advance authorization before they will provide reimbursement. When possible, our office will assist you in obtaining this authorization. *Ultimately, it is your responsibility to make sure you are taking the proper steps to obtain reimbursement from your insurer.*

Most insurance agreements require you to authorize your counselor to provide a clinical diagnosis or additional clinical information such as a treatment plan or summary, or in rare cases a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, our office has no control over what they do with it.

Contacting Your Therapist

You may leave a message at the phone number provided by your counselor. In an emergency when you are unable to reach your counselor you should contact your family physician or go to the nearest emergency room

Fees

Fees for counseling services will be determined prior to service. You will be expected to pay for each session at the time services are rendered.

Confidentiality

In general, the confidentiality of all communications between a client and counselor are protected by law, and can only be released to others with your written permission. However, there are a few exceptions:

- Subpoena by a judge
- Protection of others from harm to self
- Protection of harm to another

Should such a situation occur, your counselor will make every effort to fully discuss it with you before taking such action.

HIPAA (Health Information Portability Accountability Act of 1996)

I have been provided with a copy of Choices Notice of Privacy Practices (“Notice”). The Notice contains information regarding potential uses and disclosures of my protected health information (defined by the Health Insurance Portability and Accountability act of 1996) that may be made by Choices, and of my rights and Choices’ legal duties with respected to my protected health insurance information. I have had the opportunity to review the Notice and take a copy with me if I so choose.

Statements of Understanding

I acknowledge that I have received, have read (or have had read to me), and understand the “Outpatient Services Contract.” I further acknowledge that I have had the opportunity to ask questions about the contract with my counselor.

I do hereby seek and consent to take part in the treatment by the counselor named below. I understand that developing a treatment plan with this counselor and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to take an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this counselor.

I am aware that I may stop my treatment at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment prematurely.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment or full payment is expected.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s). cost(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive is not made, the counselor may stop treatment.

Client signature and Date: _____

I, the counselor, have discussed the issues above with the client (and/or his/her parent, guardian). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Therapist signature and Date: _____