INFORMED CONSENT FOR MENTAL HEALTH ASSESSMENT/ COUNSELING/COACHING

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. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Because of the laws of this state and the guidelines of the therapist's profession, these privacy rules will be followed:

1. All information about you will be held confidential and privileged unless the your counselor suspects or has knowledge that you are neglected or abusing a child, a senior citizen, or a disabled person, in which case, a report will be made as required by law to the appropriate law enforcement and social welfare agencies.

2. All information about you will be held confidential and privileged unless you report suicidal or homicidal ideation, intent, or plan, or if your counselor has reason to believe that you intend to harm yourself or others, in which case, a report will be made as required by law to the appropriate law enforcement and social welfare agencies.

3. Likewise, all information about you will be held confidential and privileged unless you report that you intend to harm a specific individual, in which case, the specific person will be notified of your intent to harm them and a report will be made as required by law to the appropriate law enforcement.

4. Other information may be released in accordance with the Heath Insurance Portability and Accountability Act as described in this office's Notice of Privacy Practices.

I, _____ am a competent adult voluntarily seeking assessment and/or counseling for myself. I hereby give consent to Abundance of Love and Wealth, LLC to provide counseling as described above.

____ I understand that I am financially responsible for counseling and that I understand that payment for services provided is expected at the time of service. My signature on Abundance of Love and Wealth's *Financial Policy Agreement* indicates I understand the financial policies of the office whether I pay privately, use in-network insurance, or use out-of-network insurance.

____ Although, I expect benefits from counseling, I fully understand that outcomes cannot be guaranteed. I further understand that as a result of counseling, I may experience emotional stress and feel temporarily worse during counseling that could result in life changes that could be distressing until healing begins.

____ I understand that Abundance of Love and Wealth, LLC does not provide emergency services, and I will call 911 or admit myself to the nearest crisis unit or emergency room if I feel like harming myself or another person.

ALW Counseling And Coaching
3333 Clark Rd, Ste 110
Sarasota, FL 34231

____ I understand that if my counselor believes that I am at imminent risk of harming myself, my counselor will assess or have law enforcement assess my risk of suicide and have me admitted to the nearest crisis unit for my protection if necessary.

____ I understand that if I specifically intend to harm another person, my counselor is required by law to break my confidentially and inform law enforcement and the person I intend to harm of my intent to harm them.

____ I understand that my counselor is required by law to notify the Abuse Registry if he or she suspects or has reason to believe that I am abusing children, the disabled, or the elderly.

____ I understand that regular attendance of sessions provides the maximum benefit, and hereby agree to attend all sessions unless I am ill, incapacitated, have a death of a family member, or other unforeseen circumstance.

____ I understand that I will be **billed $50.00** for missing a scheduled appointment or not canceling an appointment at least 48 hours prior to my scheduled session. **I understand I must CALL, not Text if I need to cancel or reschedule. This office does not have texting ability. It is not HIPAA compliant.**

____ **I understand I must call my therapist directly** with questions or scheduling concerns and that this office is not capable of sending or receiving text messages (with the exception of "no reply" automated text reminders).

____ I understand that I may end treatment at any time, but it would be to my advantage to give my counselor notice of leaving treatment so that your counselor can provide effective discharge planning.

____ I agree to receive telephone calls or messages from this office to the telephone contact numbers I have provided.

____ I agree to receive mailings from this office to the home address I have provided (billing statements exempt from this if declined).

Where did you hear about our services (referral source)? _____

_____ _____
Signature of client Date

_____ _____
Partner/Spouse (Relationship Counseling) Date

_____ _____
Parent/Legal Guardian (If Minor) Date

_____ _____
Witness Date

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