

COUNSELING STRATEGIES, LLC

INFORMED CONSENT

Thank you choosing to see me for your counseling needs. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

MY QUALIFICATIONS AND CREDENTIALS

I have a Masters of Education in Community Counseling from the University of Missouri – St. Louis. I am a Licensed Professional Counselor (LPC) with the State of Missouri. I offer individual, couple and family counseling services to children and adults. I generally take a solution focused, cognitive behavioral approach to counseling. Areas of particular interest include: giftedness, anxiety and successful transitions.

CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's parent/legal guardian. It is not my policy to testify in custody disputes. Noted exceptions are as follows:

- *DUTY TO WARN AND PROTECT*: If a client discloses intentions or a plan to harm another person, I am required to warn the intended victim and report this information. If a client discloses intentions or a plan to harm themselves, the client or client's parent/legal guardian will be directed to seek emergency services in the community to prevent such danger.
- *ABUSE OR NEGLECT*: If a client states or suggests he/she is physically or sexually abusing or neglecting a child or vulnerable adult, or is in danger of physical or sexual abuse or neglect themselves, I am mandated to take steps to protect the client, and required by Missouri State Law to report this information. I do not have any legal power to investigate the situation to find out all the facts. The Department of Social Services will investigate.
- *PROFESSIONAL SUPERVISION*: I sometimes consult other therapists or other professionals about my clients. This helps me in giving high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, some information will be changed or omitted, and they will be told only as much as they need to know to understand your situation.
- *MEDICAL INSURANCE*: Should you decide to use it, I will be required to disclose specific clinical information (i.e. diagnosis, dates of services) to the insurance company in order to process your claims and for you to receive reimbursement.
- *CHILD/PARENT*: Specific details of the information children share with me in session is not shared with parents so as to encourage children to be honest and forthcoming and to maintain an emotionally safe environment for them. As part of the therapeutic process I encourage children to share information with their parents. I will talk with the parent/legal guardian about how the child is progressing, specific worries or concerns, and things the child and I agree the parent/legal guardian needs to know. Sometimes I will meet with the parent/legal guardian alone or together with the child.
- *COURT ORDER*: A judge in a court of law may require the disclosure of specific information pertinent to a case before the court.

AGREEMENT FOR PARENTS

I understand that this therapist abides by state and federal regulations regarding health and medical record keeping and confidentiality (most commonly referred to as HIPAA regulations) and that a copy of this document entitled Notice of Privacy Practices has been provided for me to review.

COUNSELING STRATEGIES, LLC

INFORMED CONSENT

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I understand that there are benefits and risks to counseling, which can improve as well as upset the equilibrium in any person, relationship, or family.

I understand that when you meet with me or my child, we may talk, draw pictures, play games, or do other things to help you get to know me or my child better and understand me or my child's challenges, strengths, and goals.

I understand that this therapist is not a psychiatrist and cannot recommend or prescribe medications. I understand that this therapist does not practice law, medicine, finance or any other profession. I am not able to give you good advice from these other professional viewpoints.

I understand that I am responsible for paying fees for this service.

FINANCIAL CONSIDERATIONS

I am not a member of any health insurance plans or panels. Health insurance is a contract between you (or your employer) and your insurer; I am not part of that contract. However, I will supply you with an invoice for my services. If requested I will fill out standard forms with diagnostic and procedure codes for billing purposes, the times we met, my charges, and your payments. You can use this to apply for reimbursement.

I will readily use and share my knowledge and skills in good faith. I ask for your commitment to pay the full fee of \$90 for my services at the end of each session, unless prior arrangements have been made. If you need to cancel or reschedule an appointment, please give 24 hours notice. Any uncanceled appointments or those where insufficient notice was given will be subject to a charge at the full rate and must be paid before additional sessions are scheduled. When emergent circumstances arise, exceptions may be made.

CLIENT RIGHTS

- *RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION:* It is my normal practice to communicate with you regarding health matters or treatment concerns in person or via the phone number you provided. Sometimes I may leave messages on your voicemail. Communication via the e-mail address you provided may also be utilized for non-clinical concerns (i.e. scheduling issues, referral information, clinical forms). You have the right to request that I communicate with you in a different way.
- *RIGHT TO SERVICE WITHOUT DISCRIMINATION:* You and/or your family will not be discriminated against based upon national origin, race, gender, sexual orientation, religion or age.
- *RIGHT TO RELEASE YOUR MEDICAL RECORDS:* You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that I have acted in reliance on such authorization.
- *RIGHT TO INSPECT AND COPY YOUR MEDICAL AND BILLING RECORDS:* You have the right to inspect and obtain a copy of your information contained in your medical records. Under limited circumstance I may deny your request to inspect and copy. If you ask for a copy of any information, I may charge a reasonable fee for the costs of copying, mailing and supplies.
- *RIGHT TO REQUEST AN AMENDMENT TO YOUR MEDICAL RECORDS:* If you feel that information contained in your medical record is incorrect or incomplete, you may ask me to add information to amend the record. I will make a decision on your request with 30 days, or some cases within 60 days. Under

COUNSELING STRATEGIES, LLC
INFORMED CONSENT

certain circumstance, I may deny your request to add or amend information. If I deny your request, you have a right to file a statement that you disagree. Your statement and my response will be added to your record. To request an amendment, you must contact me directly. I will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

- *RIGHT TO AN ACCOUNTING OF DISCLOSURES:* You have the right to request an accounting of disclosures, if any, which is a list of certain disclosures such as, but not limited to, child or vulnerable adult abuse, disclosures related to suicidal or homicidal threats, and disclosures to the U.S. Dept. of Health and Human Services to evaluate compliance.
- *RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION:* You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to me directly. However, I am not required to agree to such a request.
- *RIGHT TO A PAPER COPY:* You have a right to a paper copy of his notice whether or not you have previously agreed to receive the notice electronically.
- *RIGHT TO COMPLAIN:* If you believe your privacy rights have been violated, please contact me personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.
- *RIGHT TO RECEIVE CHANGES IN POLICY:* You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from me directly.

CONSENT TO TREATMENT

I do hereby seek and consent to take part in the treatment by Amanda J. Moeller, M.Ed., LPC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

The therapist and I have discussed my or my child's situation. I have been informed of the risks and benefits of treatment, have had my questions answered, and believe I understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist permission to begin treatment, as shown by my signature below.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time.

Client or Parent/Legal Guardian Signature

Date

I have discussed the issues above with the client or client's parent/legal 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.

Amanda J. Moeller, M.Ed., LPC

Date