***www.Iwantabetterlife.net***
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# INFORMED CONSENT AND PRACTICE POLICIES

Welcome! I look forward to getting to know you and working with you. I realize that starting counseling is a major decision and congratulate you on taking the first step.

This document contains important information regarding my policies, state and federal laws and your rights. Reading and acknowledging these policies and regulations before our first session will allow us more time to talk about what brings you to counseling during our first session. You are invited to ask any questions about these policies or the counseling process at any time during the first or subsequent sessions. Please bring this completed form and the client information form(s) with you on your first visit.

## EMERGENCY POLICIES:

If the client or their guardian believes immediate attention is necessary, the client or guardian understands they are to **call 911 or go directly to the local hospital emergency room or call the local crisis hotline in your area.** Within 24 hours of notification of emergency services, I will respond by phone and subsequently offer to provide standard counseling and support to the client or the client's family. The normal hourly rate applies.

If I, the counselor, learns in session or via client communication that the client intends/threatens to hurt him/her self or others, I am obligated by law to call emergency services.

I understand the emergency situation policies:
Client(s) Initials ____________________________________________

## CONFIDENTIALITY POLICIES:

As your counselor, I will provide services in compliance with all state and federal regulations governing confidentiality of Protected Health Information (PHI). Please review the Notice of Privacy Practices (NPP) form, posted on www.Iwantabetterlife.net, which provides more information about PHI. Clinical information will be released only with specific written authorization of the client or legal guardian except when required by law as in the following situations: (a) court required release, (b) report of dependent abuse/neglect, (c) a clear and present danger to the safety and health of a client and /or others. In addition, I will discuss client information with my supervisor, Kirk Sheppard, MA, LHMC, LPCC-SUPV as required by the state of Ohio, Counseling, Social Worker, Marriage & Family Therapist Board.

## NO SECRETS POLICY FOR COUPLES AND FAMILY COUNSELING:

I practice a **"no secrets"** policy when conducting marital/couples/family therapy. This means that *confidentiality does not apply* between the couple or among family members when one member of the treatment unit requests an individual session or contacts me outside of the therapy session to share a secret. When in couples or family treatment, an individual session may be scheduled to assist in the overall treatment and when mutually agreed upon. **Please understand that any information given in individual sessions will not be held in secret in couples or family therapy.** I will encourage the person holding the secret to share the secret during the following session and will support the client in doing so. I also reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as I deem appropriate, or necessary, to support the treatment unit's overall progress and goals. If you are seeking couples or family therapy, each member of the treatment unit must read and initial sections as indicated and sign this agreement.

I have been advised of confidentiality, the online NPP form and the 'no secrets' policies:

Client(s) Initials: ______________________________________________________

**FINANCIAL/INSURANCE POLICIES:**

I am an out-of-network provider and do not submit claims. I will provide a "summary" receipt on request to the client at the end of the quarter (or at the end of therapy) which can be submitted by the client to the insurance company for reimbursement.

All clients of Gary Dittrich LPCC are responsible for full payment of counseling fees on the day of service, unless agreed upon in advance. My hourly fee for professional counseling services is **$100.00 per hour**. In the event of financial hardship, I may agree to a lower hourly rate, so please call to discuss. Payment may be made by check, cash or credit card.

If we agree on a lower rate, due to your financial situation **that rate will remain confidential**.

**Payment is expected at the time of service. A service fee of $25.00 will be incurred for returned checks.**

Our appointment time is reserved exclusively for you. Failure to show up for a scheduled appointment or provide 24 hours notice, *will result in your being charged* your hourly rate.

**SESSION LENGTH:**
A one hour session is typically 50-60 minutes, face to face. Some clients may prefer to schedule double sessions every other week.

**NO DRUGS, ALCOHOL, OR WEAPONS PERMITTED:**
No weapons, alcohol, or drugs are permitted on the premises at any time. Smoking is not permitted inside the office. Do not come to your appointment intoxicated. You will be asked to reschedule and you ***will be charged*** for the appointment as if it were a "No Show" (the hourly rate, not billable to insurance).

**Copy of this form available on request.**

**Client(s) Signature ______________________________________Date_________**

**EMERGENCY CONTACT INFORMATION:**

**In the event of an emergency, please provide a contact:**

**Name ______________________________Relationship____________________**

**Phone _______________________ Alternate Phone _______________________**

**COORDINATION OF TREAMENT:**

It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.** If you prefer to decline consent, no information will be shared.

**____You may inform my physician ____I decline to inform my physician**

**PHYSICIAN NAME:______________________________________________**

**CLINIC:_______________________________________________________**

**ADDRESS:___________________________________________________**

**PHONE:______________________________________________________**

**Client(s) Signature _____________________________________*Date*___________**

**CONSENT TO PROVIDE TREATMENT:**

I hereby provide my consent for counseling, and/or consulting services to me or my dependent. I verify that I have the right to provide such consent. I understand that I can withdraw my consent at any time with the provision of such in writing to the treatment provider(s). This consent will remain in effect until such time as I revoke it.

By initialing this form you hereby authorize and consent to clinical services by means of assessment, evaluation, treatment recommendation, counseling and referral. You acknowledge that these services do not represent exact sciences and that no promises or guarantees have been made regarding their results. You further acknowledge the right to consent, or refuse consent, to comply with any recommended procedures or interventions.

Consent to provide treatment:
Client(s) Initials ______________________________________

**CLIENT/LEGAL GUARDIAN SIGNATURE:**

I have read each of these policies. I realize that I am responsible for informing and making sure that anyone who accompanies me to the office also complies with these policies. By initialing each policy, and signing below I am indicating my agreement to follow these policies without deviation. I am also acknowledging that I have read NPP form posted online at www.Iwantabetterlife.net . I agree to abide by the terms of the stated policies and procedures.

Signature(s):_______________________________ Date: _________

Printed Name: ________________________________________

Relationship to the Client:________________________________

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