Informed Consent and Office Policies

Counseling Solutions
8800 Commerce Loop Dr.
Columbus, Ohio 43240
Phone (614) 880-9800

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 legal guardian. Noted exceptions are as follows:

- **Duty to Warn and Protect**
  When a client discloses intentions or a plan to harm another person, or when information is obtained from clients or from collateral sources that others may be at danger, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

- **Abuse of Children and Vulnerable Adults**
  If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

- **Court Order**
  Mental Health Practitioners are required to provide information in response to court orders and subpoenas.

- **Insurance Providers** (when applicable)
  Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. Only the minimum necessary information will be communicated to the carrier. By signing this contract you are consenting to a release of information about your case to your health plan. Your practitioner has no control or knowledge over what insurance companies do with the information or who has access to this information.

- **Technology**
  Cell phone usage can be intercepted by third-parties. This form or communication is used to help you with services and with coordination of services outside of your scheduled session. Your mental health practitioner is not responsible for any interception by third parties during these calls. Similarly, confidentiality cannot be assured when using the internet and in un-encrypted email messages. Should Counseling Solutions be contacted by you through the internet, this constitutes implied reciprocal use of electronic mail.

- **Other Participants**
  Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The practitioner will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the practitioner from others involved in your treatment therefore, clients under 18 cannot be assured of unconditional confidentiality from their parents. Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

- **Staff**
  A client of any clinician is considered a client of the agency. Your case may be discussed and reviewed by other clinicians and staff. All Counseling Solutions staff are held to the strictest level of confidentiality standards.

I have reviewed, understand, and agree to the stated policies regarding confidentiality. **_____Initials**

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

I have reviewed, understand, and agree to the stated policies regarding cancellation. **_____Initials**

EMERGENCIES

If known ahead of time, you must discuss any expectations you have for emergency treatment with your therapist and agree to develop and follow a step-by-step crisis plan. You may telephone your practitioner in an emergency. Your practitioner is not always immediately available by phone and may not be available in the late evening. If unavailable, your call will be returned as soon as possible. If your practitioner is unavailable, or if your crisis needs immediate attention, please proceed to the nearest hospital emergency room or call Netcare at (614) 276-2273; the Suicide Prevention Hotline at 1-800-Suicide (1-800-784-2433), or 911.

Our general philosophy regarding emergencies is that clients are assumed to be self-responsible (i.e. autonomous, functioning, not in need of day to day supervision). In addition, as private practice clinicians we cannot assume responsibility for client's day to day functioning as can institutions nor can we be available for 24-hour per day crisis care.

I have reviewed, understand, and agree to the stated policies regarding emergencies. **_____Initials**

PRACTITIONER FEES:

Payment for service is made at the end of each session at the agreed upon fee determined by practitioner and client. If utilizing your health insurance, fees will be determined by the practitioner's contracted rate with the insurance company and co-pays will be collected at the end of each session.

- Individual Sessions $150.00 per 50-60 minute session
- Couple or Family Sessions $150.00 per 50-60 minute session
- Group Sessions $ 75.00 per group session
- Missed Appointments $150.00 per 50-60 minute session or what has been determined between you and the practitioner.

I have reviewed, understand, and agree to the stated policies regarding practitioner fees. **_____Initials**

I have read this informed consent completely and have raised any questions I might have about it with my practitioner. I have received full and satisfactory response and agree to comply with all items freely and without reservations.

_____	_____	_____
Signature of Client	Print Name	Date
_____	_____	_____
Signature of Parent/Legal Representative	Print Name	Date
_____	_____	_____
Practitioners Signature	Print Name	Date