LIFEPOINT
counseling services, LLC

Client Informed Consent

Part I: Client Rights

- You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my approach and methods to you. If I see a child under the age of 14, all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the child and therapist.
- You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision without consulting with me.
- You have a right to review your records in the files which will be made available to you within 30 days of oral/written request. I do not keep any "secret notes," so please do not ask me to do so.
- **Confidentiality:** One of the most important rights involves confidentiality. Within limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is being seen in therapy, the therapist views the whole family as the client. Therefore, releases of information for family sessions require the written approval of every consenting member of the family who was present at any time during the therapeutic process. I maintain a "no secrets" policy when working with couples and families. Please refer to our "No Secrets Policy for Family Therapy and Couple Therapy."
- If you request it, any part of your record or a treatment summary in the files can be released to any person or agency you designate provided a release form is signed. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.
- You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of any actions in this regard. These limits to confidentiality include: 1) suspected abuse or neglect of a child, elderly person, or disabled person, 2) clear indication that you are in danger of harming yourself or another person or if you are unable to care for yourself, 3) in certain circumstances, a court order requiring release of information.
- **Electronic communication**: Email has significant limitations and confidentiality cannot be guaranteed. It is important to be aware that computers, unencrypted email and texts can be relatively easily accessed by unauthorized people and hence can compromise privacy and confidentiality of such communication. If you communicate confidential or private information via unencrypted email or texts, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters.
- **Litigation:** I will not voluntarily participate in any litigation or custody dispute. I will not communicate with a client's attorney and will not write or sign any letters, affidavits or reports to be used in a client's legal matters. I will not provide testimony or client records unless compelled to do so by a court of law. Should I be subpoenaed to appear as a witness in an action involving a client, the client agrees to reimburse me for time spent for preparation, travel, court appearances, etc. at the hourly rate of $375.
- **Emergency Procedures:** I am not available for emergencies. If you think you are having a psychiatric emergency or need to speak to a mental health professional immediately, call the Lancaster County Crisis Hotline at 717-394-2631, dial 911, or go to the nearest hospital emergency room.
- **Insurance:** At this time, I do not take insurance however you may submit for reimbursement by your insurance plan. Insurance claims and reimbursement are your responsibility. Contact your representative of your insurance plan to find out about your mental health benefits. I will provide a receipt containing the information that insurance companies typically require for filing claims.

Part II: Therapeutic Process

Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of family and personal goals and values.

Therapy requires that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

Part III: Fees and Length of Therapy

I/we, (Name) _____, _____,
have requested counseling/coaching services for myself/ourselves and/or the following persons for whom I/we am a legal guardian.

_____, _____,

_____, _____.

I/We understand that services will be provided by Master's Level Marriage and Family Therapists pursuing licensure as per the rules and laws in the state of PA. I/we also understand and give permission for the therapist to seek clinical supervision or consultation about my/our situation when necessary.

I/We understand that a counseling session is normally 55 minutes in length, and the fee will be $__90.00__ paid at time of the session. **I/We understand that a 24-hour cancellation notice is required to avoid paying for the session, with the exception of emergencies.**

I/We understand that Lifepoint Counseling Services may incorporate a Christian World View or Biblical component into our therapeutic services. You may decline the use of this component in your therapy sessions by initially here - _____

I/We understand that I/we can leave therapy at any time and that I/we have no moral, legal, or financial obligation to complete any minimum or maximum number of sessions.

I/we give permission to contact me/us and to leave a voice message and/or text at phone #'s as indicated and/or by mail or email as indicated on the client information form.

I/we understand that suicidal threat, homicidal threat, and any abuse by an adult to a child or of an elderly person is mandated by law to be reported by Lifepoint Counseling Services, LLC. and does not require our permission and is not a breach of confidentiality.

My/Our signatures below confirm that I/we have read the above information carefully, have had any questions answered, understand its contents, and agree to receive services for myself and/or any child under the age of 14 under these conditions.

Client Signatures: (14 years or older)

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Witness Signature:

_____ Date _____

Adapted from AAMFT - Forms – II.3 _____Copy given to client _____Copy kept in records