Name: _____ **Date:** _____

Aspects of Life
COUNSELING SERVICES

Client Consent Form

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IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: ***Aspects of Life Counseling Services LLC*** offers a wide array of counseling services, including individual, family, couples, and group services. We are staffed by skilled and experienced licensed mental health professionals. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: We provide counseling designed to address many of the issues our clients are dealing with. Your first visit will be an assessment session in which you and your therapist will determine your concerns, and if both agree that we can meet your therapeutic needs, a plan of treatment will be developed. Should you choose not to follow the plan of treatment provided to you by your therapist, services to you may be terminated.

The goal of ***Aspects of Life Counseling Services LLC*** is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current therapist are not a good fit, please discuss this matter with your therapist to determine if transferring to a more suitable therapist is right for you. If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

YOUR RIGHTS: It is the policy of ***Aspects of Life Counseling Services LLC*** that all individuals who are seeking and/or receiving services from any of our programs will be provided with effective, efficient services. These services will be directed toward health and habilitation. As an individual receiving services at our offices, you have the following rights:

To be treated with consideration and respect for human dignity;
To receive quality treatment regardless of race, religion, sex, age, ethnic background, mental and/or physically disabling condition;
To be provided confidentiality and protection from any unwarranted disclosure regarding your treatment;

To be involved in planning your treatment and to be informed about your treatment process;
To be involved in your discharge and aftercare planning;
To refuse treatment to the extent permitted by law and to be informed of the possible consequences of your actions;
To expect continuity of care from one service to another, should you need another service;
To examine and receive an explanation about the bill for your services;
To schedule an appointment with your counselor to review your record and receive any needed explanation about the contents

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 45 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your therapist. If you must cancel or reschedule your appointment, we ask that you call our office at least 24 hours in advance. This will free your appointment time for another client.

FEE SCHEDULE: discussed during visit

A reasonable fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, we will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your therapist is out of town, you will be advised and given the name of an on-call therapist.

CONFIDENTIALITY: ***Aspects of Life Counseling Services LLC*** follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned therapist to share

confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
_____	_____
_____	_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, ***Aspects of Life Counseling Services LLC*** will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.

_____	_____
Signature – Client/Parent/Guardian	Date
_____	_____
Signature – Spouse/Partner/Guardian	Date
_____	_____
Witness	Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____	_____
Client/Parent/Guardian	Date

I authorize the payment of medical benefits to the provider of services.

_____	_____
Client/Parent/Guardian	Date