Wholeness to Freedom Ministries Inc.

James L. Begley Jr. M-Div, BCPC

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Informed Consent for Couples

We voluntarily agree to participate in counseling sessions and/or consent to participation of counseling sessions together and/or individually.

We understand these sessions are confidential and the Counselor will keep confidential anything the we say with following exceptions: (1) We direct the Counselor to tell someone else, (2) the Counselor determines that we, or one of us is a danger to self or others, (3) the law requires disclosure, such as in the case of child abuse or when ordered by a court to disclose information, (4) Information shared in confidence with a supervisor or professional colleague, and as described in the *Notice of Privacy Practice*.

We understand that services will be rendered in a professional manner consistent with ethical standards and suggested donations are as follows to which we agree unless other arrangements have been made *(please discuss with your counselor)*.

Individual sessions - $90.00 Intake -$100.00 Evaluations for Individual - $100.00
Group sessions (duration 120 min.) - $45.00 Mental Health Evaluation - $275.00
Couples /Family Intake -$110.00
Couples and/or Family Sessions - $100.00 Evaluations for Couple - $200.00
Couples/Families counseling with Jim & Susan (duration 60 min) - $160.00 *(This option available on a request bases)*
Professional Time *(consultation, reports / letters, extended telephone conversations, other client services)* - $30.00 per hour

We understand that our session time has been reserved for us and in the event we cannot keep an appointment we will give at least a 24-hour notice or otherwise we will be responsible for compensation for the session. The full donation for each session is due and must be paid at the time services are rendered *(unless other agreements have been reached)* and all donation suggestions are subject to change with advanced notice. Cash, personal checks, and credit cards *(a $2.00 - $3.00 bank fee is added to each swipe)* are acceptable for payment.
Please initial the following indicating you have read, understand, and will abide with the terms outlined below.

______ ______ We understand to gain the most from the counseling process it is important to be as active, open, and honest as possible with our counselor and work toward the goals we have mutually agreed upon.

______ ______ We also acknowledge that seeing a counselor each week will be of little benefit without additional effort outside the counseling office. This work can include thinking about the material covered in our session, making ourselves aware of our behaviors, and/or working on specific assignments made by our counselor *(e.g. keeping a log, reading a special book, practicing a new skill)*.

______ ______ Even though our counselor will provide guidance and specific tools towards obtaining our goals it is our responsibility to ask clarifying questions and properly apply them.

______ ______ We understand that counseling sessions may involve the risk of remembering painful events, can elicit intense emotions, and we may find our goals change over the course of the counseling process.

______ ______ We understand the benefits of counseling, although not guaranteed, may assist us in developing healthier, more satisfying relationships, aligning our core values and principles with how we live our lives, and managing the stressors of life in a more healthy and productive manner.

______ ______ In the event of an emergency we understand to call 911 or the Brevard Crisis Line at 632-6688.

______ ______ We understand that all communications become a part of our clinical record, which is accessible to us according the *Notice of Privacy Practice* with written notification.

______ ______ We agree to make any cancellation/reschedule at least 24 hours before the scheduled appointment. We understand that if I fail to do so we will be charged the **full donation amount**.

______ ______ We understand the suggested donation and acknowledge our counselor will set up a schedule to best meet our needs.

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Client's Consent to Treatment

_____ _____ We understand that information divulged during therapy session is legally confidential and cannot be released without our written consent except for the following situations:

SECTION C: CONFIDENTIALITY POLICY

The code of ethics for counselors and the state laws regulating most kinds of counseling consider the personal information you discuss to be confidential. This means we may not reveal any information about either of you to another person without your explicit permission. Therefore, all therapeutic communications, records, and contacts with professional and support staff, as well as between you and your therapist will be held in strict confidence. Information may be released, in accordance with *Notice of Privacy Practice* (available in the lobby and/or a printed copy upon request) when:

_______ ______ The client signs a written release of information form indicating informed consent to such release;
_______ ______ The client expresses serious intent to harm himself/herself or someone else, clearly identified;
_______ ______ There is evidence or reasonable suspicion of abuse against a minor child, elderly person (sixty-five years or older), or dependent adult;
_______ ______ A subpoena or other court order is received directing the disclosure of information.

Although we cannot guarantee it, we will endeavor to apprise you of all mandated disclosure. If you have any concerns or questions about this policy please discuss them with your counselor at the earliest possible time to resolve them in your best interest.

_____ _____ We understand that we may ask questions and have our questions satisfactorily answered, as well as question any method or procedure in which we feel uncomfortable.

_____ _____ We understand that we may seek a second opinion at any time.

_____ _____ We understand we have a right to discontinue counseling sessions at any time.

_____ _____ We agree to inform our counselor as far in advance as possible if we decide to terminate therapy in order to bring a healthy closure to the counseling and the counseling relationship.

_____ _____ Discharge planning will begin as soon as it is clinically appropriate with input from us and our counselor.

_______ ______ We, the undersigned counselor and client, have read, discussed together and fully understand these stated policies and agree to honor them.

BY MY SIGNATURE BELOW WE AM INDICATING THAT WE HAVE READ THE INFORMATION LISTED ABOVE, AM AWARE OF THE BENEFITS, RISKS, AND LIMITATIONS OF COUNSELING AND AGREE TO BE RESPONSIBLE FOR ALL CHARGES ASSESSED.

Client Signature: ____ Date: _______________

Client Signature: ____ Date: _______________

Counselor:____ Date: _______________