Wholeness to Freedom Ministries Inc.

Susan E. Begley LMHC, CETP; License #MH 11717

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Informed Consent for Child and/or Adolescent

I voluntarily agree to participate in counseling sessions and/or consent to the participation of my child for counseling sessions.

I understand these sessions are confidential and the Counselor will keep confidential anything I or my child says with following exceptions: (1) the Client directs the Counselor to tell someone else, (2) the Counselor determines that the Client 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*.

I understand that services will be rendered in a professional manner consistent with ethical standards determined for Florida state licensed mental health counselors and donations are suggested as follows to which I agree unless other arrangements have been made *(please discuss with your therapist)*.

EAP and/or Program Funded – session # to be determined		Love INC Funded – to be determined
Individual sessions - $90.00 Intake -$1000.00	**Intern - $50.00**	Evaluations for Individual - $100.00
Group sessions (duration 120 min.) - $45.00		Mental Health Evaluation - $275.00
Couples Intake -$110.00		
Couples and/or Family Sessions - $1000.00	**Intern - $55.00**	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

I understand that my child's session time has been reserved for us and in the event we cannot keep an appointment I will give at least a 24-hour notice or otherwise I will be responsible for the compensation of 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 fees 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.

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

_____I 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 the session, making self aware of own behavior, and/or working on specific assignments made by the counselor for my child *(e.g. keeping a log, reading a special book, practicing a new skill)*.

_____Even though the counselor will provide guidance and specific tools towards obtaining my child's goals it is my and my child's responsibility to ask clarifying questions and properly apply them.

_____I understand that counseling sessions may involve the risk of remembering painful events, can elicit intense emotions, and I may find my child's goals change over the course of the counseling process.

_____I understand the benefits of counseling, although not guaranteed, may assist my child in developing healthier, more satisfying relationships, aligning their core values and principles with how they live life, and managing the stressors of life in a more healthy and productive manner.

_____In the event of an emergency I understand to call 911 or the Brevard Crisis Line at 632-6688.

_____I understand that all communications become a part of my child's clinical record, which is accessible to me according the *Notice of Privacy Practice* with written notification.

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

_____I understand the suggested donation and acknowledge my counselor will set up a schedule to best meet all our needs.

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Client's Consent to Treatment

_____ I understand that as the parent I will be asked to be an active participant in my child's counseling process.

_____ I understand that information divulged during therapy session is legally confidential and cannot be released without my 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 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 therapist at the earliest possible time to resolve them in your best interest.

_____I understand that I may ask questions and have my questions satisfactorily answered, as well as question any method or procedure in which I feel uncomfortable.

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

_____I understand I have a right to discontinue counseling sessions at any time.

_____ In order to bring a healthy closure to the counseling and the counseling relationship I agree to inform my child's counselor as far in advance as possible if we decide to terminate therapy.

_____Discharge planning will begin as soon as it is clinically appropriate with input from my counselor, my child and self.

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

BY SIGNATURE BELOW I AM INDICATING THAT I 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: _____

Parent or Legal Guardian:_____ Date: _____

Counselor: _____ Date: _____