

## CENTRAL CHRISTIAN COUNSELING CENTER INFORMED CONSENT FOR COUNSELING

It is important for you, as a client of Central Christian Counseling Center (the Counseling Center) to be fully informed about the therapy services you will be receiving. **Your signature below indicates that you have received, read, and understand your rights and responsibilities under this agreement and agree to enter a therapy relationship** with the Counseling Center upon the terms of this agreement.

### **The Process of Counseling**

The Counseling Center will introduce you to a therapist who will work with you to identify presenting issues and develop a plan of care to assist you. Professional counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. Change is facilitated as the client and therapist establish a mutually respectful partnership. The therapist will facilitate a process of communication and provide knowledge based on psychological growth and development. It is your obligation to identify personal goals towards which you desire to move and obstacles which may prevent that movement. The purpose of this process is to enable the client to move toward greater psychological health and satisfaction. **While the process is effective for many people there are no guarantees of success.**

### **Professional Disclosure Statement**

The Counseling Center is a Christian based ministry to serve those who need assistance. We are comprised of a team of licensed therapists who work from a Christian perspective and strive to integrate the truth of theology and psychology. We emphasize communication and responsibility within a systems framework and utilize a variety of modalities to promote the healing process. We provide individual, couple, family, and group counseling. We are committed to respecting the values of each person and to give the client a safe place in which to seek growth. **Your therapist will inform you of his/her specific therapy approach.**

### **Practical Issues**

1. **The State of Kansas, through the Behavioral Sciences Regulatory Board (BSRB), licenses mental health professionals.** As Licensed Mental Health Professionals, we are committed to practice according to the ethics of our profession. We uphold the American Association of Christian Counselor Code of Ethics. Copies of our ethical code are available if requested. Clients can contact the BSRB with questions or to register complaints about any licensed mental health professional. We ask that you contact the director of the Counseling Center if you have a concern or complaint.

2. As Mental Health Professionals, **we are ethically and legally committed to the confidentiality of disclosures that clients make.** Exceptions occur if:

- a) a client is a danger to self or to others;
- b) when there is a reason to suspect abuse or neglect of a child, an elderly person, or a disabled adult;
- c) when the judicial system orders client records to be made available.

In keeping with accepted professional practices, sometimes we request clients for their permission to consult with other professionals about the client's situation. A release of information form is provided for the client to indicate willingness to grant that permission in writing. **By signing this Informed Consent form, the client is authorizing his/her therapist to discuss case information as needed** with the Counseling Center staff, therapists, and clinical supervisor for oversight and consultation. As a counseling center we operate under the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **I acknowledge that I have received a copy of the Central Christian Counseling Center's Notice of Privacy Practices with the effective date of April 14, 2003.** \_\_\_\_\_ (initial)

3. In addition to the exceptions of confidentiality listed above, third party payers require information before they will reimburse clients for their fees. The Counseling Center does accept some insurance cases, and we do offer a sliding fee scale based upon financial need. The Staff will provide additional information of fees if needed. The standard fee for the initial session is \$139 and for subsequent sessions is \$109. A standard session is 50-minutes in length. If additional time is needed additional fees will be applied. In signing this form you agree to have any insurance reimbursement paid to the provider.

4. If the treatment we provide is covered by health insurance, you should note that many times "Managed Health Care" plans such as HMOs and PPOs require prior authorization before they will provide reimbursement for our services. If your contract with your insurance company requires that we provide it with information relevant to the services we provide we may be required to provide them with a clinical diagnosis, as well as clinical information such as treatment plans or summaries and/or copies of any records we maintain about your therapy sessions. **By signing below, you acknowledge and consent to such disclosures.**



5. If a therapist is subpoenaed to testify or submit records to the court, a fee will be assessed. For a written report, a fee of \$150 will be charged. For testifying locally, the therapist will bill \$109 per clock hour on site, and may bill up to \$50 per hour for preparation time. If out of county, travel expense will also be billed.

6. If a therapist is contacted by phone by a client, after 10 minutes a fee will be applied comparable to prorated session fees. The client will be responsible for these charges, as they can not be billed to insurance. Prorated fees may also be charged for email communication.

7. In working to achieve the potential benefits of therapy, it may require that the client make firm efforts to change. This may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not be originally intended.

8. Within the context of couple or family counseling, it is the Counseling Center's practice that whatever is shared with the therapist jointly or privately is material that is open to be shared in session. This will be left to the professional judgement of the therapist.

9. Co-payments are expected at the time of the service. You may pay with cash, check, or credit card only. A \$30 charge will be assessed for returned checks.

10. Clients will have a file created in his, her, or their name(s). The purpose of that file is to help the therapist remember relevant information and to carry out his/her responsibilities effectively and efficiently. Files will be maintained for seven years after termination of the counseling relationship at which time the file will be shredded.

11. If a client is in crisis, an on-call therapist can be contacted after hours at 316-466-1765. This is to be used for emergency purposes only.

12. Clients who need to cancel appointments are requested to do so at least 24 hours in advance. **If a client does not show up for an appointment or provide at least 24 hours notice a \$50 charge will be assessed for the first occurrence. For the second occurrence, a full session fee will be applied.** Exceptions may be warranted in the event of an emergency. Appointments can be scheduled or cancelled by contacting 683-4083 Monday through Friday between 8-5 p.m. If for some reason, your therapist must cancel an appointment, he or she will call you at the number you have provided and, if you are not there, will leave a message stating, "This is [your therapist's name] calling for [your name] and I will be unable to keep our appointment today." If you do not want us to contact you in this matter, please notify us so that we can discuss any alternative arrangements. \_\_\_\_\_ (initial)

13. In Kansas, licensed mental health professionals are required to consult with a client's primary care physician or psychiatrist whenever symptoms of a mental health diagnosis are present. The purpose of such consultation is to determine if there may be a medical condition or medication that may be causing or contributing to the client's symptoms. The client/parent/legal guardian may also choose to waive such consultation. The clinician may provide treatment or evaluation until such time that the medical consultation is obtained or waived.

I accept the consultation \_\_\_\_\_ (initial)      **or**      I waive the consultation \_\_\_\_\_ (initial)

**I have read the information above and choose to enter into a therapy relationship under the circumstances described.**

\_\_\_\_\_  
Client or Authorized Representative      Date

\_\_\_\_\_  
Relationship to the Client (if applicable)

\_\_\_\_\_  
Client or Authorized Representative      Date

\_\_\_\_\_  
Relationship to the Client (if applicable)

\_\_\_\_\_  
Therapist      Credentials      Date

