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**Informed Consent**

**COUNSELOR-CLIENT SERVICE AGREEMENT** Welcome to my practice! This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

**COUNSELING SERVICES** Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

**RISKS AND BENEFITS OF COUNSELING** Counseling has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, counseling has been shown to have benefits for individuals who undertake it. Counseling often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

**APPOINTMENTS AND CANCELLATION POLICY** Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the cancellation/late fee of $90 (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

**CONFIDENTIALITY** What you discuss during your counseling session is kept confidential. No contents of the counseling session, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions: - I may consult with a supervisor or other professional counselor in order to give you the best service. In the event I consult with another counselor, no identifying information such as your name would be released. - If you disclose a plan or threat to harm yourself, I am required by law to attempt to notify your family and legal authorities. In addition, if you disclose a plan to threat or harm another person, I am required to warn the possible victim and notify legal authorities. -If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), I must report this information o the appropriate state agency and/or legal authorities. - Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

**PROFESSIONAL FEES** You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by cash or credit card. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

**FEE SCALE**

Initial Session for Intake: $150.00 (60 Minute Session)

Individual Session: $130.00 (45-55 Minute Session)

Self-Pay/Out of Network ($100.00 (45-55 Minute Session)

No Show or Late Cancellation fee is $90.00

Fees are non-negotiable. Fees are subject to change at counselor’s discretion.

**INSURANCE** In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers.

**RECORDS** I will keep records of your counseling session, which may include a treatment plan with goals for you counseling. These records are kept to ensure a direction to your sessions and continuity in service. The records will not be shared except for the reasons discussed in the Confidentiality section. If you would like to have your records released, you are required to sign a release of information which specifies what information is to be released and to whom. These files will be kept electronically on HIPAA compliant software or in a paper file which will be kept in a locked cabinet in my office.

**PARENTS & MINORS** While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance. All other communication will require the child’s agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

**CONTACTING ME** I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911.

**CONSENT TO COUNSELING** Your signature below indicates that you have read this Agreement and agree to its terms.

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Client Signature Date

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Parent/Guardian Signature if client is under 18 years old Date