Country Crossroads Counseling, LLC

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Individual & Family Counseling
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Informed Consent

Thank you for choosing my private practice. This is intended to give you information relevant to your therapy, rights, and exceptions of confidentiality, and office policies. Please read carefully through these pages and ask any questions you may have. Your signature(s) will indicate that you have read, understood, and accept these conditions.

1. **Counseling** is a collaborative process between you and a counselor to work on areas of dissatisfaction in your life and assist you with life goals. For counseling to be most effective, it is important that you take an **active role** in the process. Counseling activities are governed by the Missouri State Board of Examiners for Professional Counselors. I do not take on clients I do not think I can help. Therefore, I will enter our relationship with optimism about our progress. If you are not satisfied with any area of our work, please raise your concerns with me at once.

2. **Time Parameters & Frequency**: Individual appointments are scheduled generally scheduled for 53-minute sessions to allow transition between clients. For your first session, you are asked to come in early or complete paper work in the comfort of your home. *Being late for an appointment by 15 minutes or more may require that you reschedule and be charge a $20 "no show" fee.* If there are two No Show's without contacting Country Crossroads Counseling, LLC will result in all scheduled appointments being cancelled. Clients are generally seen on a weekly to biweekly basis, and then may transition to less frequent sessions as change and growth occur. After terminating your treatment, your file will be formally closed. You have a right to return to therapy again in the future simply by calling and requesting a new appointment. There may be a waiting period.

It is the sole responsibility of the parent/guardian/caregiver of the client who is underage or has a disability, prior and after the session. Country Crossroads Counseling, LLC is not responsible for any child or person outside of the scheduled hour.

3. **Confidentiality**: As a Licensed Professional Counselor in the State of Missouri, I am bound by the Missouri Administrative Code for health and safety. In accordance with these rules, information obtained in the counseling session or in written form will **not** be disclosed to any outside person(s) or agency without your written permission except when such disclosure is necessary to:

1. "Protect you or someone else from imminent harm" or is otherwise legally required and/or allowed by law (such as abuse of a child, elder, or disabled person or court order). Therefore, if you make a serious threat to harm yourself or another person, the law requires me to try to protect you or that other person.
2. If you were sent to me by a court or an employer for evaluation or treatment, the court or employer expects a report from me. If this is your situation, please talk to me before you tell me anything you do not want the court or employer to know. You have a right to tell me only what you are comfortable with telling.
3. If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties.
4. Furthermore, if you want your insurance to pay for all or part of your treatment, I must be able to discuss your diagnosis and treatment with their representative. Some insurance information is transmitted to billing personal by secure fax or electronic transmission.

I put the most effort in maintaining your privacy. If we meet on the street or socially, I may not say hello or talk to you very much. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

4. **Risks**: In counseling, major life decisions are sometimes made, including decisions involving separation within families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of the counseling experience as a result of an individual's calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be too intense to deal with at this time. I will be available to discuss any of your assumptions or possible negative side effects in our work together.

5. **Electronic Transmission/Texting**: I cannot ensure the confidentiality of any form of communication through electronic (e.g. email accounts, social networks, Square, etc.) or texting. You are advised that any email sent to me via a computer in a work-place environment is legally accessible by your employer and as well as Google.

6. **Records**: I am required by law to maintain records of each time we meet. These records include a brief summary of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply. I can be called to testify about the contents of the records and I must comply. Also, in order to file for insurance reimbursement, I have to assign you a diagnosis. If you have any questions about this, please let me know. I will certainly share any information with you that I provide to an insurance provider.

7. **Consultation**: Information about you may be discussed in confidence, without revealing your identity, with other counseling professionals for the purpose of consultation and providing you the best possible service.

8. **Fees:** Individual 52 min: $100.00
Individual 26 min: $50.00

I am able to accept some forms of Medicare.

Phone Calls: Any phone calls after the initial evaluation, relating to client, lasting longer than 10 minutes, will be billed at 15 minute increment (rounded to the nearest 15 minute mark) at $20 per 15 minute increments. Please note that I have other obligations and I am not always available after hours.

Letters: Any written letters of verification or recommendation (e.g. compliance of treatment, Support Animal Housing, etc.) are a cost of $20.

Legal Fees: As part of the therapeutic process, the therapist does not feel it is beneficial to the treatment process to participate in any legal process concerning therapy that was giving through Country Crossroads Counseling, LLC. If requested, the therapist will decline. If it becomes necessary to participate (e.g. court order, subpoena), the hourly rate for this therapist's preparation and testimony in a court hearing is $200 per hour and payment will be required in advance. The hourly rate also begins from the time leaving the office to meet the requested time to arrive at the court house until testimony is complete. ***I will not*** make any recommendations as to visitation or custody regarding my clients.

**_____ Please initial if you have read and understand all fees associated with services.

9. **Payment** will be collected at the time of service prior to the session. Please have your payment ready at the beginning of the session to avoid utilizing valuable time in your session.

Client with insurance will be requested to pay for copayment at the time of the session and the therapist will then bill directly to insurance the balance of the session fee. After the insurance company has made its payment, any remaining balances (these are usually deductibles not yet met or other amounts identified by your insurance as client responsibility) will be billed to you by mail at your home address. Please review your explanation of benefits forms carefully as you receive them, because balance billing will be based on these.

All balances still outstanding after all insurance payments are received will be billed to the client at a 30 day interval. If there are no payments made within 90 days, Country Crossroads Counseling, LLC will bill 25% of your fees each month thereafter until payment is fulfilled. You will be required to leave valid credit information with this consent. Verification of credit card information is required at initial appointment.

If there are no payments after 120 days, those balances may be turned over to a collection agency, with your name and amount owed for 3rd party collections. Country Crossroads Counseling, LLC would prefer not to ever do this, please call if payments become a problem for you to discuss options.

If unusual circumstances occur and your bill has reached $150, there will be a pause in treatment until you have reduced your owed fees. Country Crossroads Counseling, LLC feels this will only cause additional stress within your life and will not support additional financial stresses that can affect one's mental health.

By signing this form, you are agreeing to payment of all fees/copayments/deductibles that are associated with services provided that are explained above.

Disclosure of Insurance Benefits:

I certify that the financial and insurance information I have provided is true and accurate to the best of my knowledge. I authorize Country Crossroads Counseling, LLC to verify information from my clinical records to my insurance company, Medicaid, or third party sources for payment of counseling services for me or my minor children. I authorize payments directly to Country Crossroads Counseling, LLC. I agree this authorization shall be valid for one year from the date shown unless I revoke this consent in writing prior to that date.

10. Cancellation: If you find it necessary to cancel an appointment, please contact me at (816) 810-5853 or countrycrossroadscounselingss@gmail.com at least 24 hours in advance; however emergencies and illness are acceptable reasons. **If you fail to inform provider, there will be a $20 fee for not showing up for your appointment**. This will be due charged to you and not billed to your insurance. You will be required to leave credit card information with this signed consent and you will be charged the $20 fee on that credit card provided at the time of your "no show." The signature on this document presents an understanding of this fee. If you are utilizing your EAP assistance, then you will lose one of your sessions appointed.

The provider may also terminate counseling sessions from the provider in the event the client has missed 3 appointments without calling to cancel 24 hours prior to the scheduled appointment.

The therapist reserves the right to cancel sessions in the case of personal or professional time conflicts but will always try to offer you a reasonable alternative time within a week of the cancelled appointment.

11. **Emergencies**: If an emergency situation for which you feel immediate attention is necessary, including suicidal or homicidal thoughts and/or actions, feel free to contact provider and if the provider does not make contact within 15 minutes, then contact **Emergency Services (911)** immediately or go to your nearest hospital emergency room. You may also text the **Crisis Text Line at 741-741 and text "START"** for assistance. *If I feel your safety is a concern, I will contact your Emergency Contact (Located on Intake Evaluation Form). By signing this form, it provides written permission to contact them in emergency situations with the discretion of the author.

12. **Safety:** If at any time the therapist feels threatened, she has the right to contact emergency personnel through security features.

13. **Emergency Contact:** By signing the Informed Consent, if are providing permission for Country Crossroads Counseling, LLC to contact your Emergency Contact Person (noted on Intake Evaluation) if there is ever safety concerns for suicidal or homicidal thoughts.

14. **Social Networks:** Due to confidentiality, I will not add you on any social networks.

15. **Agreement for Parents:**

The usefulness of therapy is extremely limited when the therapy itself becomes another matter of dispute between parents. With this in mind, and in order to best help your child, I strongly recommend that each of the child's caregivers (e.g. parents, stepparents, guardian, etc.) mutually accept the following requisites for the child's participation in therapy:

1. As your child's counselor, it is my primary responsibly to respond to your child's emotional needs. This includes, but is not limited to, contact with your child and each of his or her caregivers, and gather information relevant to understanding the best welfare of your child.
2. I ask that all caregivers remain in frequent communication regarding this child's welfare and emotional well-being.
3. I ask that all parties recognize and reaffirm that to the child, that I am the child's helper and not allied with any disputing party.
4. I strongly recommend that all caregivers involved choose to participate in pscyhoeducation for the best interest of the child.
5. Please be advised regarding the limits of confidentiality as it applies to counseling with a child in these circumstances:
    a. I keep records of all contacts relevant to your child's well-being. These records are subject to court subpoena and may, under some circumstances, be solicited by parties to your divorce, including your attorneys.
    b. Any matter brought to my attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to my attention that are irrelevant to the child's welfare may be kept in confidence. However, these matter may best be brought to the attention of others, such as attorneys, personal counselors.
    c. I am legally obligated to bring any concern regarding the child's health and safety to the attention of relevant authorities. When possible, should this necessity arrive, I will advise parties regarding my concerns.
    d. If the parties are disputing custody, I will not yield recommendations about custody. I strongly feel you should consider participation in alternative forms of negotiation and conflict resolution, including mediation and custody evaluation, rather than try to settle custody in court.

I have read and understand the "no show" policy and payment policy. I am provided this credit card information in the matter that it will be charged $20 for any "no show." If an <u>EAP client</u>, then I will lose one of my free sessions, if I do not cancel my appointment and this section does not need to be completed. The credit card will also be charged if I have a balance that has not been paid after 90 days.
****Reminder: Your payment is due at the initial appointment and this card will not be charged unless there is no payment after 90 days or a no show. If you would like to pay with this credit card at the time of your session, please notify author. Your understanding is very much appreciated!**

Credit Card Number: _____ _____ _____ _____

Exp. Date: _____/_____

CVC Code: _____

Zip Code: _____

Signature: _____

I have read, understood, agree, and consent to the above conditions of service stated. I have also been offered the notice of privacy practices HIPPA on this date and have had the opportunity to ask questions about and understand these policies.

Client Signature Date

Emergency Contact Name Phone Number

(**For Minors Only) I hereby grant permission to Suzie Seitz, PLPC, MA/Country Crossroads Counseling, LLC to counsel/assess my child, _____

I am the legal custodian of this child, and there are no court orders in effect that would prohibit me from consenting to the treatment of this child.

My signature below means that I understand and agree with all the points above.

Parent Signature Date

For Minor: Please list all other parties who have legal rights to medical records.

_____ _____