INFORMED CONSENT

Thank you for choosing Counseling and Trauma Services. Today's appointment will take approximately between 45 and 90 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Your therapist uses an eclectic treatment approach. This means that she utilizes different counseling theories, like Cognitive Behavioral, Art therapy, Eye Movement Desensitization Reprocessing (EMDR) or other counseling theories according to the needs of the client. Treatment practices, philosophy and plan limitations and risks will be discussed with you today. In order to ensure quality care it is standard procedure for your therapist to participate in peer consultation and review with other masters prepared and/or licensed therapists. Only first names are used, and confidentiality standards are maintained.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information shared with a doctor,(if necessary and with your permission), b) information you and/or you child or children report about physical or sexual abuse; then, by the Commonwealth of Pennsylvania Law, We are obligated to report this to the Department of Children and Youth Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs us that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. If an emergency situation for which you, the client or their guardian feels immediate attention is necessary and I am unavailable, the client or guardian understands that they are to contact the emergency services in the community (911) for assistance. Counseling and Trauma Services LLC will follow those emergency services with standard counseling and support to the client or the client's family.*

***Signature*_____*Date*_____**

***Signature*_____*Date*_____**

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish and we are credentialed with that insurance company. We ask that at each session you pay your co-pay or 100% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does*

not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $200.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Counseling and Trauma Services LLC.

I give permission to contact the insurance company (name of insurance company)

_____

in order to provide information required for billing of services. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes and summaries.

Signature _____ ***Date*** _____

Signature_____ ***Date***_____

Lastly, if you need to cancel or reschedule an appointment for reasons other than illness, please give 24 business hours advance notice, otherwise you will be billed at the missed appointment rate. *We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.*

Signature_____ ***Date***_____

Signature_____ ***Date***_____

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist.* ***Complete the entire name and address of your physician if you wish CTS to correspond with them. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no information will be shared.*

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME: ----------

ADDRESS:_____

PHONE: _____

***Signature*_____*Date*_____**

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS UNDER 14 YEARS OF AGE

I consent that _____ may be treated as a client by Counseling and Trauma Services LLC. Sometimes it may be necessary for us to schedule appointments during school hours. We ask for your cooperation to provide the treatment for you and your children.

Signature _____Date_____

Signature _____Date_____