

## Positive Choices Counseling Services Informed Consent

**Counseling Services:** Your therapist will provide individual and/or group therapy for individuals seeking personal growth and awareness. Your therapist reserves the right to deny services to individuals whose concerns are beyond their scope of competence as well as to any individual that abuses or misuses services in any manner, e.g. non-compliance with treatment, frequent missed appointments, delinquent payment, etc. If your therapist is unable to offer you services for your specified needs, she/he will discuss other local treatment options and possible referrals with you.

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**The Counseling Process:** The counseling process is a partnership between you and the therapist to work on areas of concern or dissatisfaction in your life, and develop growth and insight, and help you achieve your desired goals and improve your overall well-being. In order for therapy to be effective, it is necessary for both of us to take an active role in this process. Participation involves being open to the therapist's thoughts and ideas, being honest with your therapist, discussing concerns about the process with your therapist, completing outside assignments when appropriate, and providing on-going feedback to the therapist about the process. While counseling is often beneficial for many people, some people may not find therapy helpful. The counseling process can also evoke strong feelings and sometimes produce unanticipated changes in one's behaviors, thoughts, and feelings. In order for you to maximize your experience, it is helpful to discuss with your therapist any questions or discomfort you may experience during therapeutic process. Your therapist will work to help you to understand the experience and/or use different methods or techniques that may lead you towards the growth you desire.

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**Confidentiality:** Your therapist recognizes that confidentiality is essential to effective counseling. In order for therapy to work best, you must feel safe about sharing your personal information with your therapist. Your therapist will maintain this information ethically and legally confidential and will be released to other parties only with your expressed written consent.

Under most circumstances, all information about you, in written or verbal form, obtained in the counseling process (including your identity as a client) will be kept ethically and legally confidential. Information will not be disclosed to any outside person(s) or agency without your written permission except in certain situations, which include, but are not limited to:

- a. If you are determined to be in imminent danger of harming yourself or someone else.
- b. If you disclose abuse or neglect of children, the elderly, or a disabled person(s).
- c. If you disclose sexual misconduct by a mental health professional.
- d. To qualified personnel for certain kinds of audits or evaluations.
- e. In a criminal court proceeding.
- f. In legal or regulatory actions against a professional.
- g. In proceedings in which a claim is made about one's physical, emotional, or mental condition.
- h. When disclosure is relevant to any suit affecting the parent-child relationship, which includes divorce and child custody deliberations.
- i. Where otherwise legally required.
- j. Any information that you also share outside of therapy, willingly and publicly, will not be considered protected or confidential by a court.

The above is considered a summary. If you have questions about specific situations or any aspects of confidentiality, please feel free to discuss your concerns with your therapist. You may also contact your Managed Care Provider, the Louisiana Board of Social Work Examiners at [www.labswe.org](http://www.labswe.org), or the Louisiana Board of Counseling at [lpcboard@lcpboard.org](mailto:lpcboard@lcpboard.org).

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**Access to Records:** Upon request, you may review your counseling records. You will be asked to arrange an appointment with your therapist to review the information. You reserve the right to request the therapist to make corrections or additions to your records. You may be charged a full or partial session fee for administrative costs/time related to getting copies for your records. Counseling records are maintained for 6 years after your last contact with your therapist.

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**Therapist Qualifications:** Your therapist is either a licensed social worker or is being supervised by a licensed clinical social worker or a licensed professional counselor. If you would like more information about your therapist, or you would like to file a formal complaint against your therapist, please contact your Managed Care Provider, The Joint Commission for the Accreditation of Healthcare Organizations at (800)994-6610, or [complaint@jointcommission.org](mailto:complaint@jointcommission.org), the Louisiana Board of Social Work Examiners at (225)756-3470 or the Louisiana Board of Counselors at (225) 295-8444.

**Counseling Process:** You have the right to decide not to enter therapy with your therapist. If you feel that you are not making progress towards your goals, you may terminate the therapeutic relationship at any time. Your therapist will provide you with a list of referrals for therapists in the community. In an effort to help you transition, your therapist may request one last formalized session, so you can provide your therapist feedback and consider your next steps. You will be responsible for any outstanding payments for services received.

Your therapist will respect you as an individual and will convey this respect by maintaining appointments with you or by contacting you if a change in times is necessary. Your therapist will also give you her complete attention during sessions. You have the right to ask any questions, at any time, about what occurs during therapy, and to receive answers that satisfy you. If you wish, your therapist will explain her style to you. You have the right not to refuse the use of any therapy technique. If your therapist plans to use any unusual technique, the therapist will inform you and discuss the benefits and risks.

You and your therapist also will negotiate your frequency of sessions, number of sessions, goals, type of counseling (individual or group). Your therapist recommends meeting with you once a week for 50 minute sessions. You and your therapist may re-evaluate the frequency of your sessions as situations arise and/or as you move towards your goals. If you are with Louisiana Medicaid, Prior Authorization is required prior to services being provided. They will determine the amount of sessions and the duration of service provision. You are required to meet with your therapist at least twice a month to continue receiving medication management/psychiatric services.

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**Access to services:** You may reach your therapist at the designated office phone number to schedule an appointment. If it is not an emergency, your therapist will attempt to follow-up with you within 48-72 hours. If you are experiencing an emergency, please contact our 24 hour crisis intervention

Name: \_\_\_\_\_

line (866)200-4593. You can also contact your therapist at the designated phone number, which will be provided you on your therapist's business card.

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**From the office of Positive Choices Counseling Services, Inc. (2020) 1109 Carter Street, Suite 10, Vidalia, LA 71373**

**Counseling Appointments:** Therapy also is more effective when an individual attends appointments in a consistent manner. It is expected that you will be prompt for your appointment. Sometimes emergencies come up. If an appointment change or cancellation is necessary, you will be given advance notice of up to 24 hours, as we know you have a reserved time for the appointment. If for any reason you must cancel an appointment we ask that you give a minimum of 24 hour advance notice.

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**Fees:** Therapy is a personal investment in one's own growth and overall well-being. It is expected that payment will be made for the therapeutic services provided. For Louisiana Medicaid recipients, there is no additional cost to you for your sessions. For Magellan Healthcare EAP clients, a flat fee has also been contracted and there will be no additional cost to you. For private pay, the fee for service is \$100.00 for a 50 minute session and payment must be rendered prior to each session. Limited sliding scale fees are available for individuals demonstrating significant financial need and meet certain qualifications determined by the therapist. Sliding scale fees are subject to increase at any time and the discount will be terminated if the client is not consistent with appointments. Payment can be made with cash, personal check, or credit card. If you have insurance coverage, your therapist will be glad to provide you with a receipt or statement satisfactory for filing your insurance claim at the end of each session. Therapy is a significant personal and financial commitment. Please do not hesitate to discuss financial matters with your therapist.

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**Phone calls:** Your therapist recognizes situations may arise, and you may want to speak with your therapist via telephone in between sessions. You are welcome to contact your therapist, and your call will be answered when the therapist is available. Please use the crisis number if you need immediate attention. Please be aware that you will be billed in 15 minute increments, which can affect your authorized time from Medicaid.

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**Email:** Although e-mail has become a major means of communication between individuals, internet communication has significant limitations. Please note the following guidelines for use of e-mail as a form of communication with your therapist.

- Your therapist cannot provide personal counseling solely through e-mail, but your therapist may offer limited support via email. *Please be aware that email communication is not a substitute for interpersonal therapy.*
- Your therapist cannot guarantee that your e-mail will remain confidential. Although your therapist may keep your e-mail message private, your therapist cannot ensure administrators of the system and experienced computer users may be able to access e-mail, so confidentiality cannot be ensured.
- Although e-mail may seem like a fast way to contact someone, your therapist may not have the ability to check e-mail as frequently and as consistently. Absence from the office, a busy schedule, unexpected illness, or difficulty getting online may mean that several days go by before a message is received. Please call your therapist on their designated phone line to ensure communication.

The laws and rules on confidentiality are complicated. Please bear in mind that your therapist is not able to give you legal advice. If you have special or unusual concerns, and so need special advice, it is recommended strongly you speak with a lawyer to protect your interests legally and to act in your best interests.

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**Environment of care:** You are expected to maintain a safe and protective environment at all times. Children and youth should be protected from firearms, drugs, alcohol, and abuse at all times. Once unsafe environmental issues have been identified, you will be required to resolve the situation immediately. Failure to do so can/will result in the termination of services and the appropriate referral will be made.

Initials \_\_\_\_\_

**Consumer Rights & Responsibilities:** You, the consumer, have been informed at admission of the following

1. The right to privacy, security, and respect of property.
2. The right to voice a complaint or concern regarding care of service.
3. The right to participate in all aspects of care/services and planning of care/services.
4. The right to refuse all or part of his/her care to the extent permitted by law.
5. The cost of services that will be billed to his/her insurance and/or self (verbally and in writing).
6. The value or purpose of any technical procedure that will be performed, including the benefits, risks, and who will perform the task/procedure.
7. The ownership or control of the agency.
8. The right to review records.
9. The right to 24-hour crisis intervention.
10. The right for protection from abuse, neglect, retaliation, humiliation, and exploitation.

Initials \_\_\_\_\_

*The signature below indicates that I have read, discussed, understand, and agree to abide by the points presented above.*

\_\_\_\_\_  
Signature of client (or person acting for client)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

From the office of Positive Choices Counseling Services, Inc. (2020)

1109 Carter Street, Suite 10, Vidalia, LA 71373

Name: \_\_\_\_\_