# CONSENT FOR TREATMENT

**Client's Name:** _____________________________________________ **DOB:** _______________

I do hereby **consent to and authorize ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION** to perform all therapy, treatment and counseling, which is judged by it or its therapists to be necessary or advisable for me. I understand that treatment is optional, and that I may revoke consent in writing.

**Confidentiality Agreement –** *Please initial below*

_____ I agree and understand that these services are confidential, and treatment records will be maintained exclusively for my well-being.

_____ I further understand that all records of my treatment will be withheld, unless I specifically authorize a release of such information.

_____ I understand that upon termination of services, my records will be stored by ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION for seven (7) years, at which time they will be destroyed, as required by law.

**Exceptions to Confidentiality –** *Please initial below*

I understand and agree that ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION and its therapists may be legally required and are permitted to disclose my confidential communications or records, without regard to my consent, under any of the following circumstances:

______ (1) If I present a serious risk of harm to myself, to others, or to property.

______ (2) If there is a suspected instance of child abuse or elder abuse.

______ (3) If a court orders that the communications or records be disclosed.

**Technology & Communication** – *Please initial below*

____ I understand that if I communicate with my therapist via text message or email, I am consenting to allow a third-party carrier to transmit my communications, and I am aware that there is a potential for confidentiality breaches when using this technology.

____ I understand that ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION does not provide 24-hour service or crisis service. If I am unable to reach my therapist or am feeling unsafe or require immediate medical care or immediate mental health or psychiatric assistance, I understand I need to contact my primary care physician, my psychiatrist, go to the nearest emergency room or call 911.

**Risks & Benefits of Therapy** - *Please initial at the end of the paragraph*
I understand that:
Psychotherapy is a process in which therapists and clients discuss a variety of issues, events, experiences and memories to create positive change, so that clients can experience their lives more fully. Psychotherapy is a joint effort between a client and a therapist. Progress and success may vary depending upon the problems and issues being addressed. During the therapeutic process some clients feel worse before they feel better. Since therapy often involves discussing unpleasant aspects of clients' lives, clients may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness; other risks include lack of improvement and disruptions in life as a result of therapeutic changes. Even though psychotherapy has been shown to have benefits for people who go through it, including: better relationships, solutions to specific challenges, and significant reductions in feelings of distress, there are no guarantees as to what clients will experience. There may indeed be alternative treatment methods for a client's condition, and I can discuss these alternatives with my therapist at any time.

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**Termination of Therapy** - *Please initial below*

____ I understand that ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION reserves the right to terminate therapy at its discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs are outside the scope of competence or practice of therapists of ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION, or client is not making adequate progress in therapy. Clients have the right to terminate therapy at their discretion. Upon either party's decision to terminate therapy, therapists generally recommend that clients participate in at least one termination session to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION will also attempt to ensure smooth transition to another therapist by offering referrals.

**Appointments & Cancellation Policies –** *Please initial below*

____ I understand that ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION is setting aside a regular appointment time for me, and I agree to attend appointments consistently in order to hold my appointment time.

____ I further understand and agree that I will be billed for appointments that have not been canceled or rescheduled 24 hours in advance.

**Fees & Payment Agreement –** *Please initial below*

____ I agree that I am responsible for payment of $250.00 per 50 minutes session, and that a check payable to ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION or cash is due at the beginning of the session in the amount indicated.

____ I understand that my session fee is subject to an increase periodically, the amount of which will be discussed with me prior to the increase taking effect.

____ I understand that I may be billed for phone sessions and/or clinical consultations longer than ten (10) minutes at the same rate as above, pro-rated in ten-minute (10) increments, and also may be billed for shorter consultations if, cumulatively, they exceed ten (10) minutes.

____ I understand that ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION does not bill insurance directly, but may provide an itemized statement upon my request. I agree that it is my responsibility to seek reimbursement from my insurance company, if I so desire, and that **I am responsible for all fees**.

Client's Signature: ____________________________________________ Date: _______________

Received: ADVANCE, A LICENSED CLINICAL SOCIAL WORKER CORPORATION Date: ________________

by:

Therapist's signature: ________________________________________

Katya Kosarenko, LCSW