Counseling And Support Associates, PC
AT LAKE NORMAN

INFORMED CONSENT - ADULTS

Thank you for choosing Counseling And Support Associates, PC. Today's appointment will take approximately 45 – 50 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. _____ has earned a Bachelor of _____ Degree in _____ and a Masters Degree in _____ from _____. He/She is licensed by the State of North Carolina as a Licensed Professional Counselor (LPC). He/She has over ____ years of clinical experience in treating adolescents, adults and families using individual and family therapy _____. _____ practices standard _____ therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims; b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by North Carolina State Law, I am obligated to report this to the Department of Children and Family Services; c) where you sign a release of information to have specific information shared; d) if you provide information that informs me that you are in danger of harming yourself or others; e) information necessary for case supervision or consultation; f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the office to have a counselor paged. If no call is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. <YOUR NAME HERE> will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.

Signature(s) _____ **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. We ask that at each session you pay your co-pay or an agreed upon percentage 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 $300.00 we will need to ask that you pay for services when rendered. 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 Support Associates, PC.

I have received a copy of my fee schedule. _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly 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. **You may have a copy of this form if requested.**

Signature(s) _____ **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. Your consent is valid for one year. **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 inform will be shared.

_____**You may inform my physician(s)** _____**I decline to inform my physician**

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

Signature(s) _____ **Date** _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s) _____ **Date** _____

May we contact you at home (circle one) **yes no**?
May we contact you at work (circle one) **yes no?**
May we contact you by cell phone (circle one) **yes no?**

Where may we contact you? _____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ maybe treated as a client by _____. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Signature(s) _____ **Date** _____