Analog Counseling & Consulting Services, LLC.
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Informed Consent & Counseling Policies

Thank you for selecting me to meet your counseling needs. It is a privilege to serve you and I will do all I can to help with whatever need you have and to provide the highest quality of service. In order to better serve you the following information is being provided. Please examine it carefully. I will be happy to answer any questions regarding items for which you need additional clarification.

Please initial all sections below to which you agree. Any sections not initialed will be discussed prior to treatment.

____ **The Therapy Process**: I use a variety of treatment approaches in order to best help you reach your goals. Change can occur through working on one's thinking, actions, environment, and spiritual condition. Changes can produce varying results *and it is necessary to recognize that as one struggles with change, sometimes that struggle may lead one to go through a more difficult valley, even repeatedly, before a more stable experience is found*. It is very important that therapy continue until you have passed through that valley should it occur. This is a journey more than an answer to a question.

____ **Confidentiality:** I am dedicated to preserving the confidentiality and privacy of all my clients. However, some state and federal laws require that I disclose information in certain situations**. Please review the following situations in which I must breach confidentiality:**

- **If I suspect child, elderly or disabled person abuse or neglect I am required to report that information to a state agency.**
- **When a patient brings charges against the counselor.**
- **When a court orders the therapist's testimony of your records.**
- **I may sometimes talk with another professional about your case in order to get an objective point of view. In those instances your confidentiality will be maintained as no identifying information will be revealed, only the circumstances of your situation. Any professional with whom I consult will also be required by professional ethics to maintain your confidentiality. The exception will be that when I am out of town I may release your information to another therapist who will serve on call should an emergency arise. In this case a little confidential information will be released as is necessary.**
- **When I believe a patient is a danger to themselves or others (suicidal or homicidal).**

The laws and ethics of confidentiality are complicated. If you have special or unusual concerns, an attorney is recommended for legal advice.

____ **Referring On:** If you could benefit from a treatment I cannot provide, I will help you get it. You have a right to ask about such other treatments, their risks, and benefits. I will fully discuss the reasons for any additional recommendations I have so you can decide what is best.

____ **Treatment of Minors:** Persons under the age of 18 must have permission of the parent or legal guardian to receive therapeutic services. Parents will be involved in treatment as I deem necessary while maintaining the confidentiality of the client except in cases of dangerous drug use, suicidal ideation or running away. In cases of divorce, I will want to involve both parents unless rights have been severed for one or it is otherwise not feasible to do so.

I will not serve as a witness in custody disputes or provide records for such matters. I ask you to agree to accept this policy. If you go to court you will need to receive an evaluation from another professional for those involved. I will provide a summary, if necessary, but not actual records to the court. *Charge for this service will be $120 per hour of preparation.*

If required to attend court proceedings the fee will be $200 per hour. The charge can be avoided if cancellation is made one week in advance.

____ **Court Ordered Subpoenas:** If your records are requested through a court ordered subpoena, you will be notified in writing and provided with a copy of the subpoena. If you wish to refute the subpoena you must then provide the therapist with a written objection to the subpoena or indicate that an objection will be filed with the court (with a copy to the therapist). It is the client's responsibility to file this with the court within the time frame legally allowed.

____ **Appointments:** Counseling sessions are 50 minutes (unless adjusted to fit the developmental needs of a younger patient, something determined through a case by case basis or if adjusted for a couples session which

sometimes work better in a longer format). *Session time includes the time needed to schedule another appointment and make payment.* I have a 24 hour cancellation policy. Meaning, if you cancel within 24 hours of your appointment for reasons other than significant: sickness, personal or family emergencies, or major weather crisis you will be charged in full for the missed session unless the session can be rescheduled within the current work week. If you cancel three appointments in a row, we will discuss issues that may indicate the need for another therapeutic plan.

____ **Fee Policy:** Initial Session: $65 | Normal Session: $125 | Co-Therapy Session w/ Aaron & Intern: $80

PACKAGE OPTIONS

5 Sessions — $575 ($115/Session)
10 Sessions — $1,050 ($105/Session)
15 Sessions — $1,425 ($95/Session)

Patients are required to keep a credit or debit card on file. Cards will be kept in a HIPAA compliment way through a company called, Ivy. This is to ensure the ability of the counselor to recoup any missed session fees. The counselor agrees to only charge the cards on file when a) requested by the patient as normal payment form or b) when the patient has violated the cancellation or reschedule policy. Patients will be informed ahead of time if they are to be charged for missed appointments. If the patient does not opt to pay for sessions via the card on file they may use cash, check or credit card at the time of service. Payment is due in full by the end each session. Checks can be made out to Analog Counseling. Returned checks are subject to an additional $25 charge.

Two sessions without payment will cancel future sessions until the account is paid in full.

____ **Insurance:** I do not accept insurance, however, if you belong to a plan that pays for out of network services, documentation will be provided in order for you to request reimbursement. Submission and responsibility to know whether my services are redeemable through insurance lie with the patient.

____ **Communication:** When there is sensitive information I need to send you via email (such as billable receipts) I will email you via a secure email server. Billable receipts will come password protected. I ask that you do not email or text me sensitive or emotional information in order to insure your confidentiality. All other non-sensitive information (such as scheduling information) can be done via email or by phone call.

____ I acknowledge that I have received or have been offered a copy of the **HIPAA Notice of Privacy Practices**.

It may be beneficial to me to confer with your medical professional with regard to your psychological treatment or to discuss any medical problems for which you are receiving treatment. **Please check one of the following**:

____ You are authorized to contact the following physician whose name and address are shown below to discuss the treatment that I am receiving while under you care and to obtain information concerning my medical diagnosis.

Physician _____

Phone _____

____ I decline permission to contact my physician with regard to my treatment.

My signature below indicates that I accept the terms and conditions of all initialed policies above concerning my care.

_____		_____	
Signature	Date	Signature	Date
_____		_____	
Signature	Date	Signature	Date