Intuitive Counseling & Wellness

Embrace the Evolution of You

123 South Broad Street, Suite 1833, Philadelphia, PA - (610) 504-5234

INFORMED CONSENT

Welcome to Intuitive Counseling & Wellness! This document is designed to ensure that you understand the nature of the counseling process and the nature of the relationship between client and counselor well enough to give informed consent for the process to begin.

I. Purpose of Services

The counselor at Intuitive Counseling & Wellness, LLC is experienced and professionally trained. The model of treatment involves weekly or bi-weekly counseling with clients who are willing and able to work on the issues that they would like to resolve through the counseling process. You will be offered services specifically designed to help you as part of your treatment plan. Treatment may include individual, couples, or family therapy. If it appears you will benefit from medication, then you can be referred to an appropriate practitioner who will evaluate your need for medication and meet with you to monitor your response. Other complementary and alternative services may be recommended such as herbalism, reiki or acupuncture and if so, a referral to the appropriate practitioner will be made.

Both the counselor and the client are free to terminate counseling under the following circumstances: 1) If either the client or the counselor believes counseling is not being helpful to the client; 2) If the client is not complying with those elements of counseling essential for progress; 3) If the client's behavior or the behavior of someone in a relationship with the client is harmful or potentially harmful to other clients or the counselor.

II. Consent to Treatment

By signing this form, you consent to take part in counseling with the counselor named below. You understand that developing a treatment plan with this counselor and regularly reviewing the work toward meeting the treatment goals is in your best interest. You also understand that no promises have been made to you as to the results of counseling provided by this counselor.

III. Right to Refuse or Withdraw Consent

You have the right to refuse or withdraw your consent for treatment at any time.

IV. Costs, Billing and Collections

The fee for your treatment is $_____ per session of individual, couples, or family therapy. Except for brief report or messages of up to 15 minutes, you will be charged for telephone communications, report writing or other professional servicers at the rate of of $_____ per

hour. Payment is required at each session. Clients who owe money or fail to make arrangements to pay may be referred to a collection agency.

V. Limitations on Privacy and Confidentiality

Although your sessions may be very psychologically intimate, it is important for you to realize that it is a professional relationship rather than a social one. Please do not invite your counselor to any social gatherings, offer gifts, or ask them to relate to you in any way other than in the professional context of your counseling sessions. In addition to the limitations on privacy and confidentiality detailed on the signed Limitations on Privacy and Confidentiality form, by signing this form, you are consenting to have your counselor discuss your case from time to time in supervision, a counselor-to-counselor process through which counselors assist one another in their professional development by reflecting on their work with clients. While names are not routinely used, you need to be aware of the fact that your counselor's supervisor may have access to your records and will be consulted on occasion.

VI. Legal Issues

If you are in the midst of any type of legal issue such as litigation, a dispute with your employer, separation or divorce, please inform your counselor immediately. Please be aware that in custody cases, signed informed consent must be given from both parents if the client is under the age of 14, and medical records are frequently subpoenaed when litigation is involved. Please remember that Intuitive Counseling & Wellness, LLC has no control of, or responsibility for how information is handled once it is released to third parties.

VII. Appointments

Sessions are _____ minutes in length. In the event that you will not be able to keep an appointment, you must notify your counselor via text message, email, or voicemail message at least 24 hours in advance. If your counselor does not receive such advance notice, you will be responsible for paying a cancellation fee equivalent to your usual session fee.

VIII. Emergencies

Intuitive Counseling & Wellness, LLC is considered an outpatient setting. Your counselor cannot assume responsibility for your day-to-day functioning, as some more intensive treatment centers are designed to. It is the responsibility of the client to discuss expectations of out-of-session care with the counselor upon intake so that, if necessary, an appropriate referral can be made. In the case of an emergency, when a client fears harm to themself or another, please dial 911 or go to your nearest emergency room, as this is not an emergency facility.

IX. Social Networking

It is the policy of Intuitive Counseling & Wellness, LLC that counselors do not accept requests for friendship, follows or connections from clients or solicit themselves to clients as friends on social networking sites. This applies to active and non-active clients for a minimum of two years after discharge.

- Sign Overleaf -

My signature below indicates that I grant consent for Intuitive Counseling & Wellness, LLC to provide counseling to myself and/or minor members of my family. I also acknowledge that I have received a copy of Client Rights and Responsibilities, Limitations of Privacy and Confidentiality, HIPAA Notice of Privacy Practices, and Authorization for Use of Disclosure of Protected Health Records and/or Credit Card Authorization if applicable.

Client Signature Date

Parent/Guardian Signature Date

Parent/Guardian Signature Date

Counselor Signature Date

To Parents of Adolescents (14 - 18 y/o)

I understand that in the state of Pennsylvania, while I do not have the right to access my child's/ward's records, I do have the right to information about my child's/ward's counseling process including: symptoms and the conditions to be treated; medications and other treatments; and the risks, benefits, and expected results of treatment. However, I understand the need for confidentiality between my child/ward and their counselor and that confidentiality will be maintained unless the counselor determines that my child/ward is a danger to themself or to others, the counselor determines with clinical judgement that it is clinically prudent to disclose information to me (as constrained by state law as above), or my child/ward asks their counselor to facilitate the disclosure of specific information to me.

Parent/Guardian Signature Date

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LIMITS OF PRIVACY AND CONFIDENTIALITY

The content of all counseling sessions is confidential and the fact of your being in treatment is private. Neither information shared through speaking, information through writing, your records, nor knowledge of your participating in treatment can be shared by your counselor without your (or, if you are under the age of 14, your legal guardian's) explicit written consent as documented with an Authorization for Use or Disclosure of Protected Records form. The ONLY exceptions to this ethical duty of counselor's to maintain privacy and confidentiality are listed and explained below:

Duty to Warn and Protect:

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults:

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances:

Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship:

Parents or legal guardians of minors who do not fall under the categories of the Minor's Consent Act have the right to information (symptoms and the conditions to be treated; medications and other treatments; and the risks, benefits, and expected results of treatment) but not client records but only when such parents or legal guardians have consented to treatment (in the state of Pennsylvania, minors between the ages of 14 and 18 can give consent to treatment even without parent or guardian consent and in such a case would have full privacy and confidentiality as detailed above, even extending to parent/guardian knowledge of participation in counseling.)

Insurance Providers (when applicable):

Insurance companies and other third-party payers are given information that they request regarding services to clients.Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of treatment, case notes, and summaries.

My signature below indicates that I understand the Limitations of Privacy and Confidentiality and their ramifications as pertaining to my treatment at Intuitive Counseling & Wellness.

Client Signature Date

Parent/Guardian Signature Date

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CLIENT INFORMATION

Name: _____

Date of Birth: _____ Gender/Preferred Pronouns: _____

Home Address: _____

_____

Phone Number (home/cell): _____

Okay to leave a voicemail message? Yes: _____ No: _____

Okay to leave a message with someone else? Yes: _____ No: _____

Okay to text? Yes: _____ No: _____

:

Email Address: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Emergency Contact Email Address: _____

Relationship Status: _____

Current Occupational Status: _____

Current Workplace/Job Title: _____

Highest Level of Education Completed: _____

How were you referred? _____

Reason for wanting to begin counseling/psychotherapy at this time: _____

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CLIENT RIGHTS AND RESPONSIBILITIES

Client Responsibilities:

- Adhere to established schedules. If you must miss an appointment, contact your counselor as soon as possible.
- Pay your bill in accordance with the billing agreements.
- Follow agreed-upon goals and strategies established in sessions.
- Inform your professional counselor of your progress and challenges in meeting your goals.
- Participate fully in each session to help maximize a positive outcome.
- Inform your counselor if you are receiving mental health services from another professional.
- Consider appropriate referrals from your counselor.
- Avoid placing your counselor in ethical dilemmas, such as requesting to become involved in social interactions or to barter for services.

Client Rights:

- Select a professional counselor who meets your needs.
- Receive specific information about your counselor's qualifications, including education, experience, national counseling certifications, and state licensure.
- Obtain a copy of the code(s) of ethics your counselor must follow.
- Receive a written explanation of services offered, time commitments, fee scales, and billing policies prior to receipt of services.
- Understand your counselor's areas of expertise and scope of practice (e.g., career development, adolescents, couples, etc.).
- Ask questions about confidentiality and its limits as specified in state laws and professional ethical codes.
- Receive information about emergency procedures (e.g., how to contact your counselor in the event of a crisis).
- Ask questions about counseling techniques and strategies, including potential risks and benefits.
- Establish goals and evaluate progress with your counselor.
- Request additional opinions from other mental health assessment professionals.
- Understand the implications of diagnosis and the intended use of psychological reports.
- Obtain copies of records and reports.
- Terminate the counseling relationship at any time.
- Share any concerns or complaints you may have regarding a professional counselor's conduct with the appropriate professional counseling organization or licensure board.

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HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

Treatment: We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care *providers ,* DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

Payment: Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires *prior* to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

Health Care Operations: We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment , employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Minors: Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

Required by Law: We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law.

Abuse, Neglect, and Domestic Violence: Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the v1ct1m of abuse, neglect, or domestic violence and the patient agrees or it is

required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

Judicial and Administrative Proceedings: As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

Law Enforcement: We will disclose your Protected Health Information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

Coroners and Medical Examiners: We disclose Protected Health Information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.

Public Health: Your Protected Health Information may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

Health Oversight Activities: We may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections, licensures , and other activities as authorized by law.

Inmates: If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose Protected Health Information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

Military, National Security, and other Specialized Government Functions: If you are in the military or involved in national security or intelligence, we may disclose your Protected Health Information to authorized officials.

Immunizations: We will provide proof of immunizations to a school that requires a patient's immunization record prior to enrollment or admittance of a student in which you have informally agreed to the disclosure for yourself or on behalf of your legal dependent.

Worker's Compensation: We will disclose only the Protected Health Information necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

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CREDIT CARD AUTHORIZATION

All information on this form will remain confidential.

If you would like to pay for your sessions using Venmo, disregard this form.

Cardholder Name: _____

Billing Address: _____

_____

Last 4 Digits of Card Number: _____

Type of Card (VISA/Mastercard/etc.): _____

Agreed-Upon Session Fee: _____

I authorize Intuitive Counseling & Wellness, LLC to charge the agreed per-session amount listed above to my credit card provided herein. I acknowledge that I will be charged my usual session fee for all appointments missed without 24 hours advance notice, except in the case of genuine emergencies or illness.

Client Signature: _____ Date: _____