magnolia
counseling & play therapy
helping children and families blossom

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Informed Consent
Agreement for Therapeutic Services

As a client(s) or parent of a client you and/or your child have certain rights and responsibilities. Those rights and responsibilities are outlined below. .

PLEASE INITIAL ON EACH LINE. SIGNING THIS FORM INDICATES ACCEPTANCE OF THESE TERMS FOR PROVISION OF SERVICES.

_____ 1. You have the right to ask questions about your therapy. Your clinician will explain her therapy approach and methods. Your clinician will also discuss the Code of Ethics under which she practices if you desire.

_____ 2. You or your clinician have the right to end therapy at any time without any moral, legal, or financial obligations other than those already incurred. We request that if the decision is made to terminate, that a final session be scheduled to explore the reasons for termination. If a final session is not scheduled your clinician may contact you to request feedback regarding termination. Termination itself can be a constructive and useful process. If a referral is desired, it will be made at this time.

_____ 3. You have the right to specify and negotiate therapeutic goals and to renegotiate when necessary.

_____ 4. You have the right to be fully informed about fees for therapy and the method of payment required.

_____ 5. In order to communicate with insurance panels, it may be necessary to contact and share information regarding diagnosis, type of contact, frequency, and duration of sessions with your specific provider.

_____ 6. You have the right to confidentiality within certain limits. Information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency with the following exceptions:

A. You sign a written release of information indicating informed consent to such release;
B. You express serious intent to harm yourself or someone else;
C. There is evidence or reasonable suspicion of abuse against a minor child, elder person, or dependent adult;
D. A subpoena or other court order is received directing the disclosure of information (it is our policy to assert privileged communication in such a situation);

E. You are in therapy or being tested by order of a court of law (the results of the treatment or test ordered must be revealed to the court); and
F. Case consultation between the clinician and his/her clinical peers.

_____ 7. You understand that suicide risk is to be taken very seriously. You want help finding new ways to manage stress in times of crisis. You realize there are no guarantees about how crises resolve, and that your clinician is making reasonable efforts to maintain safety for everyone. You understand that in some cases hospitalization may be necessary.

_____ 8. You have the responsibility to provide us with accurate information on how we might best help you and to keep us advised of your needs throughout the therapeutic process.

_____ 9. In working to achieve the potential benefits of therapy, it may require that you make firm efforts to change and it may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners and other persons can similarly lead to discomfort, as well, relationship changes may not be originally intended.

_____ 10. Appointments are scheduled for 50 minutes, known as a "clinical" hour. The remaining 10 minutes on the "clock" hour is used by your clinician to maintain your file. Clients are expected to keep appointments as scheduled. **Because the appointment time is reserved for you, it is necessary to charge for appointments which are not canceled 24 hours in advance**, unless they are occasioned by circumstances which we would both define as an emergency. You, the client, will be solely responsible for the full cost of the canceled or missed session. If you must cancel or reschedule, notify the clinician as far in advance as possible.

If there are more than two late cancellations, defined as less than 24 hours notice of cancellation, this clinician has the right to terminate therapy.

More than 15 minutes late is considered a missed appointment and the session will be canceled.

_____ 11. You understand that all information is confidential according to HIPAA (Health Insurance Portability and Accountability Act) standards. Reception of HIPAA privacy practices and acknowledgement including verbal discussions of HIPAA expectations have taken place according to your initials.

_____ 12. You understand the scope of practice of the assigned clinician. Discussion of your clinician's experience and scope of practice.

_____ 13. If your therapist happens to see you outside of the professional setting, she will not address you unless you address her first. This is for the protection of your privacy from those who may be with you. Your therapist is happy to return a friendly greeting but will allow you to take the initiative if you would prefer to do so.

_____ 14. You understand that electronic communication through unencrypted text messages or email is not secure. It is our policy to not discuss therapeutic issues at length via text or email.

_____ I authorize my clinician to communicate with me via text at this number.

_____ I authorize my clinician to communicate with me via email at.

_____ 15. **Court appearances are billed at $200 per hour with a minimum charge of six (6) hours, for a total of one thousand two hundred ($1200) dollars.** Since the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition. The therapist asks that clients only request a court appearance in extreme cases. **Court appearances will likely result in the need to terminate therapy and refer you to another therapist.** In such cases as the therapist is ordered to testify by the court about her counseling with you or your minor child, the therapist will be monetarily compensated as set forth.

In the event that it is necessary for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for her services, including travel, preparation, and necessary expenditures at the rate of $200 per hour, rounded to the nearest half hour. These expenditures include but are not limited to copies, parking, meals, and the like. The client agrees to pay the $1200 two weeks prior to the appearance, presentation of records, or testimony requested. All additional expenditures will be billed after the court appearance if the time extends past (6) hours.

Other letters and paperwork requested by the client will be assessed a charge of $100 per hour, rounded to the nearest hour, with a minimum 1 hour charge. This does include letters to court officials or attorneys and any other documentation requested by the client. This does not include copies of your bill, missed work or school letters, Release of Information Forms, nor any other documents used in the day-to-day operation of the office.

I will NOT perform social studies or custody evaluations. I will NOT provide recommendations regarding possession, custody, access to or visitation with minor children.

_____ 17. We hope that we will mutually agree on when your child's treatment goals have been met, so we can schedule final sessions to review progress and develop a plan for the future. However, there are a few instances in which your therapist may terminate therapy before reaching that point. If we believe that our approach and training is no longer appropriate for your specific concerns, or that your child is not benefitting from treatment, we will inform you that we can no longer provide services and give you referrals to other mental health professionals who may be better suited to meet your child's needs. We understand that any termination may be difficult, but your therapist's decision on this matter will be final. If you request and authorize it in writing, your therapist will confer with your child's new therapist to help with the transition.

Sick Policy

_____ 1. Further if you or your child is experiencing any of the following symptoms the session will need to be canceled: fever, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.

_____ 2. You will limit the number of individuals brought to each session.

_____ 3. If a resident of your home is tested for COVID and/or tests positive, you will let me know and our session will be rescheduled as necessary.

Social Media Policy

_____ 1. I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). I believe that this can compromise your confidentiality and privacy.

_____ 2. Please do not use messaging on social networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure, and I may not read the message in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

_____ 3. It is not a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes

necessary as part of ensuring your welfare. These are unusual situations, and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

ACKNOWLEDGEMENT AND SIGNATURE

I have read the Magnolia Counseling & Play Therapy, LLC Notice of Privacy Practices ("Notice") and Informed Consent and Therapy Agreement ("Agreement") carefully. I understand the terms of the Notice and the Agreement and I agree to comply with them.

I understand that the Notice may be changed from time to time, as required by law. I also understand that I may not be notified when any changes are made, but the current version of the Notice will always be on the website for Magnolia Counseling & Play Therapy, LLC.

I have had a chance to ask questions about the Notice and Agreement before signing below. I understand that the Agreement is a contract between me and Magnolia Counseling & Play Therapy, LLC, and may be enforced as a written contract. I agree that the Agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated after the date of the Agreement and must be provided to Megan Peters, LCPC, RPT before the revocation will take effect. I agree that a copy of the Agreement has the same force and effect as the original.

_____ _____

Client/Guardian Signature Date Client Signature Date

_____ _____

Client/Guardian Signature Date Client Signature Date

_____

Clinician Signature Date

Revised: 06.08.2023