Stacy Smith Counseling LLC

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CONSENT FOR TREATMENT

Confidentiality

I understand that all services provided are strictly confidential, and no information can be released without my written consent. However, I understand that, *by law*, Stacy Smith is required to break confidentiality in the following cases:

1) There is good reason to believe I am a danger to myself. Stacy Smith has the right to call for emergency services if I am unable to contract for safety.
2) There is good reason to believe I am a danger to someone else. Stacy Smith must take steps to warn the other party of my intentions, and to take measures that will ensure their safety.
3) There is good reason to believe that I am abusing or neglecting a child or vulnerable adult. Stacy Smith must inform Child or Adult Protective Services.
4) If my records are subpoenaed in a court of law.

I understand that Stacy Smith may occasionally need to consult with other professionals in their areas of expertise in order to provide me with the best treatment. Information about me may be shared in this context without using my name, date of birth, or other personal means of identification.

Availability

I understand that I am free to leave a voicemail message at any time. While every effort will be made to return my calls within 24 hours, I understand there is no guarantee that my call will be returned immediately. I understand that Stacy Smith does not provide 24-hour crisis service, and that I am urged to call 911, or go to the nearest emergency room, in the event I feel unsafe or require immediate medical or psychiatric assistance.

Communication

The best way to communicate with Stacy Smith is by phone. E-mail and text message communication is ***NOT*** considered secure. Should I choose to communicate via these methods, I fully understand that all information I communicate, as well as the response I receive, is ***NOT*** protected, and my confidentiality is at risk with an unwanted third party viewer and disseminator. I also understand that E-mail and text messages are not to be used to communicate urgent matters or emergencies.

Social Media and Community Encounters

Stacy Smith does not accept social media requests from former or current clients. If I happen to see Stacy in the community, I understand that in an effort to maintain my privacy and confidentiality, she will not acknowledge me first. While I may say hello, I agree to keep the conversation brief, and refrain from discussing personal topics related to my treatment.

Fees and Payment

I understand that Stacy Smith is considered an out-of-network provider, and that the fee for the initial intake assessment is $275. Each subsequent session is 55 minutes with a fee of $250. I may pay in the form of cash, check, or credit card, and understand that payment is due on the day of service. Stacy Smith can submit an out-of-network claim to my insurance carrier for possible reimbursement of fees already paid, or she may print out a receipt that I can submit on my own. I authorize Stacy Smith to release any necessary information to my insurance carrier in order to process insurance claims, including protected healthcare information.

Termination of Treatment

I understand I am participating in treatment with Stacy Smith voluntarily, and am free to terminate at any time. While it is best to let Stacy know of my decision, I understand she has a right to close my case if I have not been in communication with her for at least three weeks, and do not have a future appointment scheduled. I also recognize that if Stacy Smith believes I will best be served by a provider who is better able to meet my needs, or believes a higher level of care is more appropriate, Stacy has a right to provide me with appropriate referral options and terminate my care.

Cancellation and Lateness

I understand that if I must cancel an appointment, I must do so at least **24 hours** in advance. If I miss a session with no advanced notice, or do not call to cancel at least 24 hours before a scheduled appointment, I understand I will be responsible for the *full* session fee of $250, and that insurance *cannot* be used to cover the cost. I understand that if I am late for a session, the time missed will *not* be made up during that session, and I am responsible for the full session fee.

_____ By initialing here, I attest that I have read and understood the Cancellation Policy above, and agree to abide by its terms.

Community-Based Treatment

Stacy Smith may recommend that some sessions take place in the community so that I may have support with practicing skills in the "real world" setting. I understand that engaging in community-based interventions is optional, and that while Stacy Smith will do her best to respect my confidentiality, I recognize that confidentiality cannot be guaranteed when conducting therapy in a public environment.

Credit Card Information

I understand Stacy Smith requires a credit card to be kept on file for the purposes of collecting late cancellation and no-show fees, as well as any balances owed on my account. By providing my information below, I authorize Stacy Smith to use my card for the above-stated purposes.

Name on Card:_____

Card Number:_____

Security Code:_____

Expiration Date:_____

Zip Code:_____

Finally, I understand that while every effort will be made to promote successful changes, I recognize that counseling is not an exact science, and that no guarantees can be made with respect to treatment outcome.

My signature below indicates that I, _____ , understand and agree with all statements made above, and agree to allow Stacy Smith to provide me with counseling services.

_____

Name (print) Signature Date