

RED MOUNTAIN COUNSELING CENTER, LLC

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CONSENT FOR ASSESSMENT AND TREATMENT

Welcome to my counseling practice. Therapy is a unique relationship between the client and therapist. I have developed this document in order to ensure that there are no misunderstandings about the various aspects of counseling and psychotherapy services. Although this document is long and perhaps complex, it is important that you read it carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. This revocation will be binding on me unless I have taken action in reliance on it.

Background and Services

I am a professional counselor in an independent private counseling practice. My credentials include a Master's degree in professional counseling from Ottawa University and licensing by the Arizona Board of Behavioral Health Examiners.

I believe that a strong relationship with Jesus Christ facilitates a person leading a healthy, productive life. It is not essential that you share my Christian beliefs, but you have the right to know that my value assumptions are rooted in my Christian faith.

The helping relationship is based on using counseling techniques that facilitate the understanding of how spiritual, mental- emotional, social and physical constituents interact both to create and maintain distress or to achieve wellness. I offer counseling and psychotherapy services to individual adults, couples and families in the area of mental health, relationships, adjustment, and trauma resolution. The primary focus of my practice is adults. Adolescents are also seen when a parent participates in treatment. Clients that present in counseling with eating disorders, violent behaviors or certain personality disorders as their primary problem will be referred to other professionals or programs that specialize in these areas. I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experience.

Financial Agreement

Payment is expected at the time the service is rendered unless other arrangements have been made. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. Currently, my fees are as follows:

Initial assessment - \$115.00

Individual 50 minute session - \$105.00

Family or couples 50 minute session - \$125.00

Sessions that run longer than 50 minutes will be charged in 15-minute increments.

Late Cancellation Fee - \$50.00

Upon scheduling your first appointment, you will be required to give your credit card information and agree to authorize Ann M. Warner, Red Mountain Counseling Center, to charge that card for your sessions in the event that other payment has not been made at the time of service, or in the event of late cancellation or missed session that was not cancelled prior to 24 hour notice policy. I also offer phone sessions which are billed at \$25.00 per 15 minutes should you feel that this would be beneficial for your needs between regular in-office sessions. These sessions are on a limited basis as time allows. At this time, I accept CASH, CHECK, or VISA/MASTERCARD.

I reserve the right to change my fees with 30 days notice and to use the services of a third-party collections service, when necessary. Refunds are not made after the services have been rendered. You have the right to be informed of all fees that you are required to pay and my

refund and collection policies. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments. In circumstances of financial hardship, I may be willing to negotiate a payment installation plan.

Insurance

Currently, the only insurance company I contract with is Blue Cross Blue Shield. I will provide signed insurance forms for your reimbursement if you are using insurance besides BCBS. *You are responsible for the full fee regardless of your insurance company's reimbursement policy.* Your insurance company or managed care company may limit the number of sessions based on their assessment or medical necessity or other factors. Their determination may or may not match what you want or need in treatment. In the event that they will not authorize additional sessions or you exhaust the sessions that your insurance will provide, you understand that you will have to pay for the additional services rendered. As was indicated in the section, *Privacy, Confidentiality and Records* you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems which are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

Using a third party to pay for the counseling implies that some information will be released in order to obtain payment for services. Please see the *HIPAA NOTICE OF PRIVACY PRACTICES* for more information.

Availability of Services

My practice does *not* have the capacity to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to the local crisis hotline at 602-222-9444. Established clients with an urgent need to make contact may use my cell number, *but an immediate response is not guaranteed.* A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation.

Appointments

Regular attendance to your scheduled appointments is very important to a successful outcome in therapy. I have reserved an hour or more for your appointment. Appointments canceled at the last minute are detrimental to my practice and to your treatment. A minimum notification of one full business day prior to your appointment (24 hours, Monday through Friday) is required for cancellations or you will be charged a cancellation fee of \$50.00. Repeated late cancellations or missed appointments (more than 2) will be billed at the full fee and may result in termination of therapy. In addition, if you arrive more than 15 minutes late to an appointment, you will be billed for a full session. If you are billing an insurance company, it must be for a partial session and you will be expected to make up the difference.

Appointment availability varies with the client load at the time. High demand appointments (off hours, late afternoons, and weekends) are likely to be sporadic in their availability. I reserve the right to limit my commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload.

Privacy, Confidentiality, and Records

Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statutes. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved. I also participate in a process where selected cases are discussed with other professional colleagues to facilitate my continued growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with treatment approaches and methods.

It is important to be aware that I use a number of electronic tools in my practice, including computers and the internet, email, fax machines, telephones, and a cell phone. I may use these

tools to store or communicate information about you and your treatment. While reasonable backup, security, and other safeguards are in place, there is always some risk of inadvertent disclosure of information that comes with using these tools. By signing this informed consent, you agree to accept the risk of disclosure that comes with tools that I use in my practice.

When I am out of town or otherwise unavailable, I will typically have another licensed therapist on call for me. I reserve the right to disclose confidential information from your records and our time together, including personally identifiable information, to this on-call therapist to facilitate the coverage of your care in my absence.

There are also numerous other circumstances when information may be released including but not limited to when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against me, to comply with other federal, state or local laws. The rules and laws regarding confidentiality, privacy, and records are complex. The *HIPAA NOTICE OF PRIVACY PRACTICES* included in this packet of information, details the considerations regarding confidentiality, privacy, and your records. This packet also contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so. Periodically, the *HIPAA NOTICE OF PRIVACY PRACTICES* may be revised. Any changes to these privacy practices will be posted in my office, but you will not receive an individual notification of the updates. ***It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.***

I have read the *HIPAA NOTICE OF PRIVACY PRACTICES* and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the *HIPAA NOTICE OF PRIVACY PRACTICES* is incorporated by reference into this agreement. _____

Initials

If you would like me to speak with another healthcare provider or obtain records from previous treatment, you will need to sign a "Release of Information" form. If one of the unusual circumstances previously stated does arise when I am forced to release information about you, I will personally contact you and will do everything in my power to release minimal information.

In the event of my death, retirement, or incapacity, the records for my clients who are actively receiving services (seen within the last month) will be given to one or more local behavioral health professionals to facilitate the continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by a "records custodian" which may be an individual or a company. The custodian will be responsible for satisfying records requests and destroying records when the legal timeframes for records retention are satisfied.

Purpose, Limitations, and Risks of Treatment

Counseling has been shown to have many benefits, including better relationships, solutions to specific issues, and significant reduction in feelings of distress. However there are no guarantees of what you will experience. The process of therapy involves working through tough personal issues that may result in uncomfortable emotions such as anger, fear, or frustration. Attempting to resolve these issues may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use, education, relationships, or any other area of your life.

Sometimes, a decision that is personal growth for one family member is viewed negatively by another family member. Change can be easy, but usually it is slow and frustrating. In family or couples counseling, interpersonal conflict may increase as we discuss family problems and issues.

In most cases, one or more mental health diagnoses will be rendered during the process of assessment and treatment. Some diagnoses may affect employment in high security or safety sensitive positions or affect your ability to obtain future insurance.

You have the right to refuse any recommended treatment or to withdraw consent to therapy and to be advised of the possible consequences of withdrawal or refusal. I welcome your

input and questions about our course of treatment. *Your satisfaction in therapy is very important to me.*

Dual Relationships

Our relationship is very unique and it is exclusively a therapeutic, professional relationship. Thus, it is inappropriate for a client and therapist to have a social relationship. The local faith community can be a small community. Consequently, you may bump into me at church or out in the community. I will never acknowledge working therapeutically with you without your written permission. Bestowing gifts and attending family or religious functions would be a violation of the boundaries of our therapeutic relationship that serves to protect your confidentiality.

If you ever feel you have been treated unfairly or disrespectfully, please talk to me about it. This is never my intention, but at times misunderstandings can result in hurt feelings. Addressing these issues right away is important so that your progress in therapy is not hindered.

Treatment Process and Rights

Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan.

Litigation Considerations

If you become involved in the legal system (divorce, custody, civil litigation, criminal activity, etc.) you can expect that I will not make recommendations, testify, or get otherwise involved in your legal activities. It is an inherent conflict of interest for a treating professional to also offer evaluations or opinions in legal matters. If a client has these expectations, it can affect their willingness to disclose personal information vital to treatment. If you need an evaluation for the legal reason, I will make a referral to an outside, unbiased professional who can perform this service. ***In signing this agreement, you agree that you will not call me as a witness to testify or to expect recommendations or other involvement in your legal activities.***

Consent for Evaluation and Treatment

Consent is hereby given for evaluation and treatment under the terms described in this consent document and the *HIPAA NOTICE OF PRIVACY PRACTICES*. I acknowledge that I have received a copy of this informed consent agreement and the *HIPAA NOTICE OF PRIVACY PRACTICES*. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Printed Name: _____

Signature: _____

Date: _____

In the case of a minor child, please specify the following:

Full name of minor: _____ **DOB:** _____ **Relationship:** _____

Full name of minor: _____ **DOB:** _____ **Relationship:** _____

For office use only – verification that client has read and understands informed consent document.

Authorized Representative: _____ Date: _____