



CLIENT INFORMED CONSENT FORM

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:

All interactions with NuView Counseling, LLC including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety.
- Alabama state law requires that staff of NuView Counseling, LLC who learn of, or strongly suspect physical or sexual abuse, neglect of any person under 18 years of age, or sexual misconduct of a Physician or Therapist, must report this information to county child protection services.
- A court order, issued by a judge, may subpoena NuView Counseling, LLC to release information contained in records and/or require a therapist to testify in a court hearing.

If you are referred to Health, Mental Health, or Substance Abuse professionals, you, (the client), are responsible for their charges.

Except as noted above, no information regarding a client shall be released without the prior written consent of the client or in the case of a minor, the written consent of the parent or legal guardian.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of NuView Counseling, LLC.

Signature of Client

Signature of Therapist

Date

Any suspected violations of counselor ethics may be reported in writing to the following agency:

**THE ALABAMA STATE BOARD OF EXAMINERS
950 22nd Street North, Suite 765, Birmingham, AL 35203**



Informed Consent for Telemental Health Services

The following information is provided to clients seeking Telemental health therapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully and note any questions you would like to discuss.

Client's Rights

- ♣ You have the right to decide to end our psychotherapy work at any time without prejudice.
- ♣ You have the right to ask any questions about procedures used during therapy.
- ♣ You have the right to refuse the use of any therapeutic technique.
- ♣ You have the right to learn about alternative methods of treatment
- ♣ Telemental health services are not appropriate for all clients. Should Telemental health services not be a good fit for you, I will assist you in finding alternative options.

Benefits and Risks

Telemental health refers to psychotherapy services that occur via phone, email, or synchronous video conferencing. All of our interactions will fall under this term. When using technology there is always the risk of security issues, as well as technical issues (phone not charged, computer or software not working, etc.). In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows therapists to connect with people who may otherwise not be able to access services, there is an opportunity for more flexibility in scheduling, and personal convenience. In order to protect your confidentiality and to facilitate the security of your information as much as possible, here is a list of recommendations:

- ♣ Engage in sessions in a private location where you cannot be heard by others.
- ♣ Use a private phone.
- ♣ Do not record any sessions.
- ♣ Password protect all equipment and/or software used in Therapy.
- ♣ Always log out or hang up once sessions are complete.

Emergency Management Plan

NuView Counseling does not provide emergency services. In the event of an emergency, please call 911 or go to your nearest Emergency Room.

Authorization for Treatment

I, _____, authorize evaluation and treatment from **NuView Counseling LLC**, and acknowledge that I may request a copy of this informed consent agreement. It is agreed that either of us may discontinue treatment at any time.

Signature

Date



Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Referring Therapist _____

Spouse _____

Children) _____

Other _____

Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____



**CLIENT CONSENT TO PSYCHOTHERAPY AND
RELEASE OF INFORMATION TO YOUR INSURANCE COMPANY.**

I consent to the use of a diagnosis in billing, insurance filing. I understand my rights and responsibilities as a client/parent or legal guardian to client and the therapist's responsibilities to me. I agree to undertake therapy for myself/for my child with Charlie Brown, LPC. I know I can end therapy at any time and that I can refuse any requests or suggestions made by the therapist.

I have read this statement, considered it carefully, asked questions that I needed to, and understand it.

Signed

Date

Signed

Date



Policy and Procedures (About Our Fees)

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Usual and customary fees are assessed for a 45-50 minute counseling session for \$136.00 and initial Intake fee is \$136.00. Should a session last more than 50 minutes, fees will be adjusted accordingly. Phone consultations that last longer than 15 minutes are subject to the usual and customary fee.

Payment is to be made at the conclusion of each session and all checks should be made payable to Charlie Brown, NuView Counseling. Please note that there will be a \$30.00 fee assessed for any returned check.

I understand that my fee will be **\$136.00** for each counseling session and due at time of service. Please initial X .

Client Commitment to Counseling

We are committed to providing you with a professional counseling service. To assist us with our efforts, we ask that you read and sign the following agreement.

I, will make every effort to come for each counseling appointment. If it is necessary to cancel an appointment, I understand that this should be done at least 24 hours in advance. Should I fail to notify the counselor and miss an appointment, I understand that a \$25.00 fee will be assessed and that it will be my responsibility to pay for the missed session. Further, should I need to reschedule an appointment, I understand that fees will be assessed based on the following schedule:

24 hour notice = no charge

Failing to show for an appointment without notification = \$25.00.

X _____
Signature of client or parent/guardian Date:

Electronic Communication

Charlie Brown, LPC will try to protect clients from possible violations with confidentiality and avoid harm in any possible way.

Due to the influx of electronic communication and technology expansion within the counseling field, it is recommended by the ACA Code of Ethics that firmer guidelines be covered in the client intake form. Therefore, please read and sign:

If I, _____, choose to communicate with Charlie Brown, LPC by electronic means, (email, phone or text) I will be charged at the amount of \$25 for each email, telephone call or text that is counseling related. If, however, the communication is an administrative task, such as “please call me when you get a chance” or a session reminder, you will not be charged a fee; you will also not be charged if you receive emails or texts from your counselor/therapist. Any other email, phone call or text other than this is considered by ACA Ethics as “counseling”.

I also understand that emails and texts are checked when possible but not frequently (i.e. when days are fully scheduled with clients, week-ends, when attending conferences, or out of town).

I have read and understand all the above statements (session fees, client commitment, limits to confidentiality and the disclosure statement) and I voluntarily consent to treatment for myself or for the child whom is being seen.

Signature of client/parent/legal guardian: _____

Signature of witness: _____ Date: _____

Explanation of No Court Testimony

I understand that services entered into with Charles Brown, LPC are strictly for counseling purposes only. Mr. Brown will NOT provide court testimony or engage in child custody litigation. In addition, as a Licensed Professional Counselor, Mr. Brown is not permitted by the State of AL to provide any projective testimony.

I agree to seek the services of a 3rd party if I find it necessary to enter into child custody litigation or need court/projective testimony. I understand that these services may be best provided by a Licensed Child Psychologist. I will not seek these services from Charlie Brown, LPC, so that the therapeutic relationship can remain intact.

Signature of client/parent/legal guardian Date

Charles Brown, LPC Date