Inner Peace
Coaching & Counseling

INFORMED CONSENT FOR COUNSELING

Client Name (Print): ____ **DOB**: _______________ **SS #:** ________ _______ ________

Thank you for choosing Inner Peace Coaching & Counseling. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of office policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

I, Linda J. Stockton, earned a Bachelor of Arts Degree in Personnel from Purdue University (Fort Wayne, IN) and a Masters of Arts Degree in Counseling from Marshall University Graduate College (South Charleston, WV). I am a Nationally Certified Counselor, a Certified Clinical Mental Health Counselor, a member of the American Counseling Association and I am a Licensed Professional Clinical Counselor (Ohio). I have clinical experience in treating individuals age 10+, adults, couples/dyads, families, and groups.

For most conditions, I primarily use Cognitive-Behavioral Therapy (looking at the importance of your thoughts in how you feel and what you do), though I frequently draw from other theoretical frameworks as well depending on the person or situation. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY & EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for:

- information used to treat you, run my company, and share with your insurance company to process your claims (optional);
- information you and/or your child(ren) report about child abuse or elder abuse; then, by Ohio State Law, I am obligated to report this to the Department of Children and Family Services or appropriate authorities;
- if you provide information that informs me that you are in imminent danger of harming yourself or others;
    - Do you possess gun(s)/weapons? Yes__ No__; What type? ______________________________________
    - Do you have a license for gun(s)? Yes__ No__ Where are they kept? ______________________________
    - Emergency contact name/phone: ____
- where you sign a release of information to have specific information shared;
- information necessary for consultation, case supervision or to address workers' compensation and other Government requests
- defense of malpractice or professional complaint
- collection of debt per Financial/Insurance Policies on Page 2
- when required by law or by court order.

If you have an emergency or are in crisis, you or your parent/guardian are to call 911 or go to the nearest emergency room. Do NOT call me first. I will be available to follow up emergency services with standard counseling. If an urgent non-life-threatening situation for which you or your parent/guardian feels attention is necessary before your next appointment, please call the office at 513-201-5949; after business hours call my cell phone at 419-722-2032. There is no charge for calls lasting less than 15 minutes. I do not utilize email or text messaging to communicate with clients or parents/guardians; emails and texts are not confidential.

____ ____________________________________

Client Signature Date

____ ____________________________________

Parent/Guardian Signature (if client < age 18) Date

FINANCIAL/INSURACE POLICIES: Payment in full is expected at the beginning of your session unless we have signed a fee waiver*. I accept cash, checks, money orders, and debit/credit/HSA cards. It may be possible for you to get some of the money back from your insurance company if you file a claim under out-of-network benefits and include your receipt, which contains all the required information for your insurance plan to process the claim.

When the client is a minor and the parents are estranged, divorced or legally separated, office policy is to designate the person who initiated counseling to be the Guarantor. I am not able to bill each person for his/her "share" of the costs as designated by the divorce decree or other legal document. The expectation is for the person who initiated counseling to be responsible for the bill and to gain any reimbursement from the other parent.

In the event of non-payment after several warning letters, Inner Peace Coaching & Counseling may utilize a collection agency of its choice to secure payment and/or take you to small claims court. By signing this page, you waive your right to confidentiality of any information needed to pursue collection of your entire account balance through these methods.

FEE SCHEDULE EFFECTIVE 01/01/16:

CPT Code	Professional Service	Fee*
90791	Psychiatric diagnostic evaluation/**intake assessment**	$150
90837 & 90839	Psychotherapy/psychotherapy for crisis, 60 min. w/patient &/or family member	$200/$240
90849	Multiple-family group psychotherapy, 60 minutes	$150
90834	**Psychotherapy, 45 minutes w/patient or family member**	$100
90846 & 90847	**Family psychotherapy/conjoint psychotherapy** with/without patient present, **45 minutes**	$120
90840	Psychotherapy for crisis add-on for each additional 30 minutes of psychotherapy used in conjunction with code 90839	$ 75
90832	Psychotherapy, 30 minutes w/patient and/or family member	$ 50
90853	Group psychotherapy (other than multiple-family group), 60-90 min.	$ 50
90785	Interactive complexity add-on code used in conjunction with codes for primary service: 90791, 90832, 90834, 90837 and 90853	$ 50
Phone consultations 16 minutes or longer (first 15 minutes are free) – not covered by insurance		$ 25/15 min.
Late Cancellation /Missed Appointment/No Show **(See Policy Below)**		$ 50
Returned check fee for NSF (non-sufficient funds)		$ 25
Fee for replying to subpoena, court testimony, depositions, travel miles/time portal to portal, wait time, my attorney fees, and time spent in preparation; **this is regardless of action/outcome**		$120/hr. + expenses

*To reflect my core values, I set aside 10% of my case load for pro bono (free) services upon request on a first-come-first-served basis and for a limited number of sessions. Pro bono appointments may be restricted to non-peak hours (Tuesday through Friday before 3:00 p.m.) and require execution of a "Fee Waiver" with my signature prior to delivery of service(s).

Late Cancellation/No Show Policies: Cancellation of an appointment is expected no later than the **calendar day prior** to the scheduled appointment by calling my office (not my cell phone) at 513-201-5949 and leaving a voice mail message. Failure to do so will result in a $50.00 "late cancellation" fee due immediately upon receipt of an invoice. Failure to call or show up for a scheduled appointment will result in a $50.00 "no show" fee due immediately upon receipt of an invoice. In the case of inclement weather, only you can decide if you can safely drive to your appointment; however, failure to show for your appointment due to weather will still be subject to the "late cancellation/no show" policy/fee unless a Level III snow emergency is in effect. In the event I cancel your appointment with less than 24 hours' notice to you, I will provide you with a coupon that waives one future late cancellation/no show fee that you might otherwise incur.

____ ______________________

Client/Responsible Party (Parent/Guardian if client <18) Date

COORDINATION OF TREAMENT/CONTINUITY OF CARE:
If you want your health care providers to work together, I need your written permission to communicate with your primary care physician, OB-GYN and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time; however, a revocation is not valid to the extent that I have acted in reliance on such authorization. If you prefer to decline consent, no information will be shared.

____I decline to inform my physician and/or psychiatrist.
____Yes, you may inform my physician(s).

Information to be shared (check all that apply):
___ 1) Social History/Intake Summary
___ 2) Psychological tests and evaluations
___ 3) Education-Vocational assessments
___ 4) Verbal/written reports from counseling sessions
___ 5) Alcohol/substance abuse&/or dependence issues
___ 6) Treatment issues
___ 7) Diagnosis
___ 8) Compliance
___ 9) Other ____

Physician/Name: ____ Clinic: ____
Address: ____
Phone: ____ Fax: ____

____ ____
Client Signature Date
____ ____
Parent/Guardian Signature (if client < age 18) Date

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:
□ Yes □ No I/We have read and received a copy of the Notice of Privacy Practices (HIPAA) & Client Rights documents.

Please indicate which of the following is/are acceptable forms of communication (including leaving messages):
□ Yes □ No Contact you by phone? ____
□ Yes □ No Contact you at home mailing address? ____
If no, contact you at (other)? ____

____ ____
Client Signature Date
____ ____
Parent/Guardian Signature (if client < age 18) Date

PROVISION TO AVOID ABANDONMENT:
In the unlikely event that I, Linda J. Stockton LPCC, am unable to provide services permanently or for an extended prior of time (e.g., death, disability, etc.), my designated Records Custodian will contact you. S/he will offer to either provide subsequent counseling services or assist you in finding a new therapist. In addition, s/he will respond to requests for copies of records.

DURATION OF COUNSELING RELATIONSHIP:
If 90 days lapse without your making and keeping an appointment, I will assume you are no longer interested in participating in counseling with Inner Peace Coaching & Counseling and will close your chart (move it to inactive status), thus ending our counseling relationship. If you want to resume counseling in the future, please call my office to discuss setting an appointment for a new intake assessment.

____ ____
Client Signature Date
____ _______________ ___________________________________
Parent/Guardian Signature (if client < age 18) Date

CONSENT FOR TREATMENT OF CHILD OR ADOLESCENT < AGE 18:

I/We consent that (child's/adolescent's name) ____ may be treated as a client by Inner Peace Coaching & Counseling.

A limited number of appointments are available after school hours; however, at times it may be necessary to schedule appointments during school hours. Upon request, Inner Peace Coaching & Counseling will provide a signed form stating the date and time the client had an appointment.

This consent to treat expires: a) at the end of treatment; b) when revoked in writing by the parent(s)/guardian(s) who initiated treatment; or c) when the child turns 18.

____ ____
Client Signature Date

____ ____
Parent/Guardian Signature (if client < age 18) Date