

INFORMED CONSENT

Thank you for choosing *FIRST CHOICE DUI & COUNSELING SERVICES, LTD.* Today's appointment will take approximately 50–55 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have questions or concerns, please ask and we will try our best to give you all the information you need. *BETTE L. HUNT, LCPC, CADC* has earned a Bachelor of Arts Degree in Psychology, a Master's Degree in Counseling, and is a Certified Alcohol and Drug Counselor. She is licensed by the State of Illinois as a Licensed Clinical Professional Counselor. She has over Ten (10) years of clinical experience in treating adolescents, adults and families using individual and family therapy. *Bette L. Hunt* practices standard therapy for most conditions, although other treatment approaches are used depending on the person or situation. Treatment practices, philosophy and plan imitations and risks will be discussed with you today. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today.

There can be some risks to being in counseling. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others. Counseling can sometimes lead to intense emotions, and at times clients feel worse before they feel better. However, counseling often leads to significant symptom reduction, increased satisfaction in interpersonal relationships, greater personal awareness and insight and increased skills for managing stress. While I cannot guarantee outcomes, I can guarantee to do my best for you and/or family.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for: A. Information (diagnosis and dates of service) shared with your insurance company to process your claims. B. Information you and/or your child or children report about physical abuse, sexual abuse, elder or disabled abuse; then, by Illinois State Law, I am obligated to report this to DCFS. C. Where you sign a release of information to have specific information shared. D. As outlined by HIPAA Client Rights and Privacy Practices. E. Where you sign a release of information to have specific information shared. F. If you provide information that informs me that you are in danger of harming yourself or others. G. Information necessary for case supervision or consultation. H. If you are determined to be a clear and present danger to yourself or others and are developmentally or intellectually disabled, then I am mandated to report you to the Department of Human Services. I. When required by law.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, and we have not been able to answer your call or other message or you cannot wait, the client or guardian understands that they are to contact the emergency services in the community (911 or nearest hospital emergency room) for those services.

_____ will follow those emergency services with standard counseling and support to the client or the client's family.

Signature: _____ Date: _____

Printed Name: _____

FINANCIAL INSURANCE ISSUES

The initial assessment appointment fee is \$180.00 and \$150.00 for follow up sessions for individual, family or couples therapy. Payment is due at the time of service. If you will be using insurance, you will pay the copayment determined by your insurance company at each session. As a courtesy, we will bill your insurance company, HMO, responsible party or third-party payer for you if you wish. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds \$300.00, we will need to ask that you pay for services when rendered. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). There is a charge of \$50.00 for NSF checks. If an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for collection fees charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Bette L. Hunt.

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the full hourly rate. We sincerely appreciate your cooperation, and at any time should you have questions regarding insurance, fees, balances or payments please feel free to ask. I have received a copy of the fee schedule.

Signature: _____ Date: _____

Printed Name: _____

COMMUNICATION & SOCIAL MEDIA

Preferred methods of interacting with me are in person (session) or by phone. Email is only used for scheduling (making, rescheduling, or appointment reminders). We do not correspond via email regarding clinical information. Many of the social media modes of communication can put your privacy at risk and can be inconsistent with HIPAA and the standards of my profession. E-mail, text messages, and social networking sites are not confidential nor HIPAA compliant, and I may not be able to respond.

I cannot respond to social media contacts on any social networking site; for example, a “friend” request on Facebook. This is to protect your confidentiality and our counseling relationship. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. We try to return messages as quickly as possible Monday through Friday. Routine messages left on the weekend may be returned Monday. We cannot guarantee 24-hour crisis coverage. If we should see each other in public I will not initiate contact. However, if you would like to acknowledge me, I will respond.

Signature: _____ Date: _____

Printed Name: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I/We have read and received a copy of the Notice of Privacy Practices and Client Rights document.

May we contact you at home? (Circle one): YES NO

May we contact you at work? (Circle one): YES NO

May we contact you by cell phone? (Circle one): YES NO

Phone Number(s)/Location(s) of how you would like us to contact you:

Signature: _____ Date: _____

Printed Name: _____

COORDINATION OF TREATMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician (PCP) and/or psychiatrist. If you prefer to decline consent, no information will be shared.

_____ You may inform my physician(s). If you agree, you will be asked to sign a release of Information.

_____ I decline to inform my physician.

Physician/Psychiatrist name: _____

Address: _____

Phone: _____ Fax: _____

DIVORCE/SEPARATION AGREEMENT

When Bette L. Hunt provides services to individuals, children or adults, of families experiencing separation or divorce, the purpose is to help the client and, not to become a witness in the proceedings. Bette L. Hunt will not participate in or provide opinion in any custody arrangements, visitation schedules, or other family court matters.

Again, we would like to welcome you. We look forward to our work together and hope that this will be the beginning of a useful and beneficial professional relationship. The effectiveness of counseling is directly dependent on a working collaboration between the therapist and the client.

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask questions and have received satisfactory answers. I consent for myself or my minor child to receive counseling services with Bette L. Hunt. I certify that I have the legal right to authorize treatment for myself and/or my minor child.

Signature: _____ Date: _____

Printed Name: _____