

## Introduction and Consent to Treat

Client(s) Name:

---

Address:

---

Phone Numbers:

---

Date(s) of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_

**YOUR COUNSELING DECISION:** Your decision to enter counseling is a very important step in your life and growth. Whether this counseling is for you alone or as a couple, or as a part of a family, it is a gift - a gift of respect- for yourself and your relationships. This introduction is provided for you to take home, read and discuss (if you are in a couple or family), sign and return at the second session. You may copy this document for your own records.

**FEE:** Fees are based on our cost of providing professional services to you and on your ability to pay. Payment is made for a unit of service (a counseling session) and not for a certain number of minutes or participants. If ever you have concerns or difficulties with fees or payment, please let your therapist know right away. Although the usual session is 45 to 50 minutes, the precise length may vary. Often couples and families schedule "double" sessions.

**PAYMENT AND INSURANCE:** Please pay at the time of service. In order to keep fees low, we have no billing service, nor do we take assignment from insurance companies. (However, we do bill for Blue Cross Blue Shield PPO.) We can provide you with the information you need to seek reimbursement from your insurance carrier. All client fees must be paid in full by the end of the month for counseling to continue. Periodically it may be necessary to adjust your fee, e.g. annually, or when weekly sessions become every other week or monthly.

**SCHEDULING SESSIONS:** For a successful therapy experience, it is essential to establish an effective working relationship with the therapist with regular and consistent series of meetings. Sessions are usually scheduled one at a time either weekly, or every other week. On occasion, more frequent visits may be needed. Extended or double sessions are sometimes helpful, particularly for couples and families. During the time you are in counseling, plan to make your appointments one of the top priorities in your schedule.

Counseling requires the commitment of all parties involved. Clients usually find that it takes more than one session to determine if they have a good fit with their therapist. It also takes about 4-6 weeks for the therapist to complete a basic assessment and plan for treatment. If there is not a good fit, I am professionally committed to helping you find a therapist who will be a better match. This will be discussed with you during the

initial session. You and I will develop your course in therapy together. If you should decide that you wish to terminate therapy, Please give at least one week's notice and plan for a summary interview to effectively end our work together.

Nothing about therapy is intended to be mysterious. Anything your therapist says or does is open for discussion. Please feel free to ask questions at any time about the therapeutic relationship or business matters.

**CANCELLATIONS:** Because your therapy is very important, your appointment is reserved for you and is not available to anyone else. Please call immediately if you must cancel. Cancellation of appointments without charge is possible only in the case of illness, injury or extreme emergency. Normal charges are incurred for missed appointments. If you must cancel, if we are able to reschedule within that work week, I don't charge for the first missed appointment.

**CONFIDENTIALITY:** Confidentiality is taken very seriously. As a client you have a legal right to have your work kept private. This is your right to **confidentiality** and it is generally the duty of your therapist not disclose to anyone anything you reveal in your session. As you begin your therapy journey, it is important that you talk with your therapist about the limits to confidentiality in therapy. Most of the time these limits do not affect therapy. However, Illinois law does require that your therapist tell others about things you have talked about in therapy **in certain cases**. It is important that you understand these exceptions.

1. The courts can require your therapist to release details that involve murder, deciding mental competency, or in cases in which wills are challenged.
2. Your therapist must tell others if there is a clear risk of serious physical or other harm occurring to yourself or others. That is, if you threaten to hurt yourself or others your therapist is required by law to report that information.
3. Illinois law requires your therapist to report within 24 hours if he or she suspects child abuse or neglect.
4. Illinois law also allows your therapist to share details of your case with supervisors, consultants, appropriate staff, or others reviewing your case for the purpose of assuring the quality of therapy.
5. With your written permission, your therapist may reveal certain information to your insurance company. Usually you give that permission when you sign a claim form, or sign the following release.
6. With your direct written permission, your therapist can give information to others that you request; e.g. your physician or school counselors.

In our experience these limits to confidentiality rarely pose a problem for our clients. We feel that informing you at the onset of our work together adds to the trust that will grow between you and your therapist.

If you are bringing your children in for therapy, it is important to think about how we will work together to balance your need for information as a parent with the need of children to establish an open and trusting relationship with the therapist. In therapy children are encouraged to communicate directly with parents about counseling and all matters of importance. Often parents and children work together in therapy to facilitate this relationship.

### **TREATMENT OF MINORS:**

In Illinois, children over the age of twelve can consent to their own brief mental health care if necessary. This is a new law, which has received the grateful support of most parents because it provides for the immediate care of children in high risk situations. However, it is our philosophy that the wellbeing of children is most often intimately tied to their relationship with their parent or parents or guardians. Respectful care of the whole family is our preferred approach to helping children.

In this office all clients have both rights and responsibilities.

You have the right to:

1. receive courteous, professional treatment at all times, including an atmosphere free of sexual harassment or abuse,
2. participate in the development of your treatment plan,
3. review your record and insert comments correcting personal information, in the presence of your therapist.

You also have the responsibility to:

- 1 cooperate with the goals you established with your therapist,
- 2 be present for all appointments; and
- 3 pay for counseling at the time of service.

HIPPA: <http://www.hhs.gov/ocr/hipaa/>

Betsy Ritzman is a Licensed Clinical Professional Counselor. Her Illinois License number is 180-001294. She is a member of the American Association of Pastoral Counselors. She has a Masters of Science in Counseling and a Master of Divinity in Pastoral Counseling. Please feel free to ask her about her credentials, experience, and any other information you would appreciate.

## Consent to Treat

I agree to attend (Fill in one): a) \_\_\_\_\_ sessions, b) \_\_\_\_\_ Open ended sessions. The fee for my counseling as mutually agreed upon is \_\_\_\_\_ per week, \_\_\_\_\_ every other week, \_\_\_\_\_ per double session, or \_\_\_\_\_ per monthly session.

I wish my therapist to disclose a diagnosis and other clinical information to my insurance company. Thus, (please sign the following) "I authorize the release of any psychological information necessary to process insurance claims. "

Signature: \_\_\_\_\_ Date \_\_\_\_\_

I have read, understood and accept the preceding information and guidelines about counseling and confidentiality.

\_\_\_\_\_  
Client Signature                      Date                      Client Signature                      Date

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

**EMERGENCY NAME:** If we need to contact someone in a dire emergency on your behalf, who do you wish that to be? Fortunately, this is hardly ever necessary.

Thank you.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

### MAIL

It is acceptable to contact me by mail: \_\_\_ Yes \_\_\_ No