**INSPIRING HEALING AND HOPE COUNSELING AND DEVELOPMENT CENTER, LLC**

**INFORMED CONSENT**

**CLIENT/THERAPIST RELATIONSHIP**: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

**RISKS AND BENEFITS:** Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

**NATURE OF SERVICES:** As a license professional counselor, I provide long and short-term counseling for individuals and families. My therapeutic approach, goals for therapy, and duration will be discussed with you individually.

**CONFIDENTIALITY:** With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I Within the limits of the law, information you provide during the course of treatment is kept strictly confidential. Information about you and your treatment will not be released to any other person or agency without your express written consent. You may choose to release information to other people or entities you designate by filling out and signing a release of information form provided to you by your therapist. Releases are active for 1 year from date of signature unless otherwise indicated. You may revoke a release at any time, but protection from disclosure does not apply to information released prior to the date of revocation.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

1.) If I determine that you pose a significant risk of harm to yourself or others I may disclose your confidential information to ensure your safety and the safety of the public.

 2.) If during the course of treatment, you disclose to me, or by my observation I have reason to suspect, abuse or neglect of a minor child or incapacitated adult, I am mandated by law to report this information to designated legal authorities. I do not have to inform you when I make such a report.

3.) When a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specified in the order to the court.

 4.) When you threaten serious bodily injury or death to another person and I determine that harm to this individual is both imminent and foreseeable, I am required under the “Duty to Warn” law to notify law enforcement and/or warn the intended victim.

**RECORD KEEPING:** I keep brief records of each session noting the dates we meet, the topics we cover, progress reports from the client’s perspective, interventions and impressions from the therapist and next steps. You have the right to review or to request a copy of your medical record at any time. You must make this request in writing. I have 30 days to respond to your request and to provide you with a copy of your record.

**EMERGENCIES:** You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. Office hours are Monday-Friday, 8:00am-6:00 pm. If your emergency arises after hours or on a weekend, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, you will be advised and given the name of an another Therapist.

**APPOINTMENTS**: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. If you must cancel or reschedule your appointment, I ask that you call our office at 404-907-6635 at least 24 hours in advance, whenever possible. This will free your appointment time for another client. Appointments not cancelled within 24 hours will result in a actual session fee.

 **CONSENT TO TREATMENT**: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in the Information and Client Consent form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I voluntarily agree to receive mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

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Signature – Client/Parent Date

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Signature –Parent/Guardian Date

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Therapist Date