Family Life Counseling – Carol A. Larson, MA, LIMHP, LPC
124 W 46th Street, Ste. 204, Kearney, NE 68847-8348 – (308) 236-2014

CLIENT INFORMED CONSENT CONTRACT

THERAPIST

Carol A. Larson, MSEd, MA is a licensed independent mental health practitioner (LIMHP) / licensed professional counselor (LPC) by the state of Nebraska engaged in private practice providing mental health care services to clients. Carol holds an earned Master of Arts Degree in Clinical Mental Health Counseling from Grace University in Omaha, Nebraska (2010).

Initial here if this section has been read and understood_____ _____

MENTAL HEALTH SERVICES

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. Using my knowledge of human development and behavior, as your therapist, I will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur.

Initial here if this section has been read and understood_____ _____

APPOINTMENTS

Appointments may be made by calling 308-236-2014. Please call to cancel or reschedule at least **24 hours in advance**, or **you will be charged for the missed appointment.** (Third party payers will not cover or reimburse for missed appointments.) Remember that scheduling an appointment means that it will be held only for you. If you are late, the session will still end on time. Therapy appointments are usually 45-60 minutes in length. The number of sessions needed depends on many factors and will be discussed with you. Any client who does not appear for an appointment that has not been cancelled and does not contact the therapist within the following six weeks will be dismissed from the client caseload. Similarly, erratic attendance of sessions may result in referral to other services. I do not wish to eliminate anyone who is in need of continued service; however, repeatedly not showing up for appointments and failing to contact the therapist indicates that a person is no longer in need of my services.

Initial here if this section has been read and understood_____ _____

RELATIONSHIP

Your relationship with your therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that your therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Your therapist cares about helping you, but is not in a position to be your friend or to have a social or personal relationship with you. Gifts, bartering, and trading services are not appropriate and should not be shared between you and the therapist.

Initial here if this section has been read and understood_____ _____

CONFIDENTIALITY:

Confidentiality of the issues discussed during the course of treatment is protected by the standards and ethics of the profession. **You will receive a HIPAA Notice of Privacy Practices form**, which explains some aspects of confidentiality. No information will be released without the client's written consent unless mandated by law. Possible **exceptions to confidentiality** include, but are not limited to the following situations: suspected child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; suits in which the mental health of a party is in issue; situations in which the therapist has the duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose. If a client becomes actively suicidal, the therapist will arrange for a higher level of care; if a client becomes homicidal, the therapist will warn the intended victim and notify the police; if a client becomes gravely ill during session, the therapist may call 911 without permission. If a client has a communicable and life-threatening STD, the client's sexual partners may be warned.

If you have any questions regarding confidentiality, you should discuss them with the therapist. By signing this informed consent contract, you are giving your consent to this therapist to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Initial here if this section has been read and understood_____ _____

To comply with Federal HIPPA regulations concerning safety of Health Care Information, you are provided with the opportunity to read the Notice of Privacy Practices. I am providing you with a copy for you to read and take with you. The initialing of this form acknowledges that you had the opportunity to do so. I understand that if I have any questions regarding this Notice of Privacy Practices or of my privacy rights, I can contact my therapist.

Initial here if this section has been read and understood_____ _____

GOALS, PURPOSES, TECHNIQUES, AND RISKS OF THERAPY

There may be alternative ways to effectively treat the problems you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the therapist and to have input into setting the goals of your therapy. As therapy progresses, these may change. Be forewarned that engaging in therapy may involve discussing uncomfortable past traumatic events, and/or experiencing depression, anger, anxiety, or other difficult, intense emotions. Even good changes can be painful. Please note that it is impossible to guarantee any specific results regarding your counseling goals. However, together we will work to achieve the best possible results for you.

Initial here if this section has been read and understood_____ _____

ETHICS AND PROFESSIONAL STANDARDS:

As a professional, I work to uphold the most responsible, ethical, and professional standards possible, and am accountable to you. If you have any questions or concerns about your course of contact, please feel free to discuss these issues with me. In signing this contract you are agreeing that should you have any dissatisfaction(s) or concern(s) about your treatment, or should you wish to contract with another therapist for services, that you will do your best to indicate that you are making the change and why you wish to change. If you are unhappy with the services at Family Life Counseling and need help finding additional or alternative assistance, I will do my best to assist you in locating alternative therapy resources.

Initial here if this section has been read and understood_____ _____

ENDING THERAPY

Just as entering into psychotherapy is an important step, terminating from therapy is as well. Termination should be planned for with at least one session in advance notice and never over the phone or through a secretary. In some cases termination is completed after the last weekly session, while for others it may be more appropriate to move to periodic sessions or "check-ups."

Initial here if this section has been read and understood_____ _____

QUESTIONS

If during the course of therapy you have questions about the nature of your therapy (i.e. goals, procedures, etc.), please ask. Your signature below indicates that you have read these office policies and agree to enter therapy under these conditions. Further, it indicates your understanding that your therapy may be terminated by your therapist if you do not comply with the policies or if your therapist feels you are not benefiting from treatment.

Initial here if this section has been read and understood_____ _____

CLIENT RESPONSIBILITIES

- The client is responsible for providing accurate and complete information about his/her status.
- The client must accept the responsibilities of his/her actions if he/she refuses treatment.
- The client must be considerate of the rights of other patients and personnel.
- The client must quiet their cell phone during sessions.
- The client must be respectful of the property of other persons and the counseling facility.
- The client must assume responsibility for the financial obligations that are involved.
- The client will not bring alcohol, drugs, weapons, or sharp objects into the facilities.

Initial here if this section has been read and understood_____ _____

If the client does not fulfill his/her responsibilities, services may be terminated.

EMERGENCY

In the case of a *life threatening emergency*, please call 911 or the National Suicide Prevention Lifeline (800-273-8255) and ask for help. Clients may also call the Richard Young Hospital in Kearney, NE at 308-865-2000.

I acknowledge that I have received a copy of this signed informed consent form from my therapist on this _____day of

_____, 20_____.

_____ _____

Client Therapist: Carol A. Larson, MA, LIMHP

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Spouse / Partner / Parent / Guardian (please circle)