LIVING HOPE COUNSELING
Erica Gores, LMFT

Informed Consent for Assessment and Treatment
Child/Adolescent

Welcome to my counseling practice. I am pleased that you have scheduled your appointment with me and have chosen Living Hope for your counseling needs. Please take a moment to review the information included in this packet. A counseling situation offers a unique relationship between the two of us. In order that we start our relationship in a healthy way, I have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling and psychotherapy services.

Education and Services. I have a Bachelor of Arts in Psychology from Wheaton College. My credentials include a Master of Arts in Marriage and Family Therpy. I am licensed by the Arizona Board of Behavioral Health Examiners as a Marriage & Family Therapist, (LMFT). My skills include being level II trained in EMDR, which is specialty training in trauma.

I enjoy working as a team with my clients to achieve their therapy goals. I believe in an integrative approach that uses a variety of modalities, treatments, and methods to best fit each individual client. I work with individuals, couples, families, children, and adolescents to help bring hope and healing to painful, and often difficult situations.

Explanation of Counseling Fees. Payment for counseling is expected at the time of service unless other arrangements have been made. Currently, the fee for an initial assessment is $150, and the fee for a 50 minute session is $150. Establishment of fees is a matter between the client and the therapist. I reserve the right to change my fees with 30 days notice and to use the services of a third party collections service, when necessary. At times other expenses occur in the course of counseling such as making copies of requested files, coordination of care with other providers, court documentation, etc. Services will be billed at your normal, hourly rate. Phone calls that exceed 10 minutes will be billed in 15 minute increments at the hourly rate.

Insurance. I do not bill insurance companies. If you are using an insurance program, I will supply you with a superbill that you can turn into your insurance company so they can reimburse you directly. In all cases, however, payment for services is due at the time of service and is ultimately the responsibility of the client, not the insurance company. You are responsible for the full fee regardless of your insurance company's reimbursement policy.

Appointments. Regular attendance at your scheduled appointments is one of the ways to a successful outcome in counseling. I reserve 50 minutes for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day prior to your appointment if you need to cancel. ***You will be billed for appointments you fail to cancel in accordance with this policy. Currently, the fee billed for this is $50 for the first late cancel. Additional late cancellations or missed appointments will be billed at the full fee and may result in termination of treatment. All "no show" appointments will be billed at the full session fee.***
Appointment availability varies with the client load at the time. High demand appointments are likely to be sporadic in their availability. I reserve the right to limit my commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload.

Availability of Services. My practice does not have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or the local hotlines (Crisis Hotline at: 602-222-9444, Samaritan Help Line at 602-254-4357, Empact at 480-784-1500 for 24 hour emergency services.) Established clients with an urgent need to make contact with me may call me on my cell phone, but an immediate response in not guaranteed. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation.

Privacy, confidentiality, and records. Ordinarily, all communication and records created in this process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statutes. The most common of these exceptions are when there is a real or potential life or death emergency, risk of harm to self or others, when the court issues a court order, or when child/elder abuse or neglect is involved. Keep in mind that records are accessed by properly executed written releases, subpoena, or court order consistent with federal law. Records are in the custody of this licensed health professional and will remain in her confidential care. In order to access your record, there must be a signed release from all identified clients who initially started counseling, and we prefer a request be made in writing with 14 days notice. I also participate in a process where selected cases are discussed with other professional colleagues to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. It is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records. It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. I will not share with you specific content that child has disclosed to me without your child's consent, or unless I believe it would be therapeutically beneficial to the child.

To currently locate or access medical records, please contact Erica Gores at: 16421 N. Tatum Blvd. Suite #124, Phoenix, AZ 85032, 602-363-5713. If this practice is terminated or sold and this therapist is not otherwise available, please check the website at www.livinghopeforyou.com for updated information to contact an identified designee to locate and access records. Records are retained for six years after the last date an adult client received the professional services. If a client is a minor, records are retained the later of: three years after a child client's eighteenth birthday or six years after the last date of professional services. Records are stored in a secure area not accessible to anyone other than this Therapist and/or a qualified designee. Records are disposed of after the stated period of retention are shredded and/or incinerated.

Electronics. It is important to be aware that computers, cell phones, and email in particular are vulnerable to unauthorized access. Please notify us if you decide to avoid or limit, in any way, the use of any or all communication devices such as email, cell phone/text or faxes. Otherwise, please note if you communicate any confidential or private information through these means that you have made the decision to take the risk that these communication may be intercepted. While reasonable back up security and other safeguards are in place, there is always some risk of inadvertent disclosure of information that comes with using these devices. By signing this informed consent, you agree to accept the risk of disclosure that comes with communication tools being intercepted.

Purpose, limitations, and risks of treatment. Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, through a process of assessment, exploration and interventions, there are no guarantees that the treatment provided will yield positive or intended results. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. Clients that present in counseling with sexually abusive or violent behaviors or certain personality disorders as their primary problem will be referred to other professionals or programs that specialize in these areas. I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experience.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision. However, I ask that you allow me the option of having a closing session with the child to appropriately end the treatment relationship.

Treatment process and rights. Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. Periodically we will review the treatment plan to monitor progress, and reevaluate for needed changes. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal.

Client/Therapist Relationship. The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstanding can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

Court

Although my responsibility to your child may require my involvement in conflicts between the two of you, my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither parent will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done. Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. I am not an evaluator of custody or visitation time. Therapists are limited in their testimony to facts such as how often counseling has taken place, and what the course of treatment has been. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision.

By signing this you agree to protect the therapeutic relationship between myself and your child by maintain these boundaries between legal matters and therapy.

However, if I am subpoenaed to be in court, this will necessitate that I clear my schedule to be "on call" for the court appearance and you will be responsible for the following testimony fees:

- There is a fixed **non-refundable** retainer of $1600 due in advance based on my fee of $300 per hour during the entire time I am at court, or at a deposition, and time out of office regardless of whether or not I actually end up testifying that day, or how many minutes I am there.
- There is a $200 express charge (in addition to the retainer) for any subpoena, or notice to meet with or communicate with attorneys without a minimum of 48 hours notice.
- There is a $400 fee (in addition to the retainer) for any reset in the case date without at least 72 hours notice.
- All fees are doubled if I had scheduled plans to be out of town.
- Other expenses may occur such as parking, making copies, travel time, notary service, and the time spent preparing for court. All time spent is billed at the rate of $300 per hour.
- There is a fee of $125 an hour for letter or report writing. Any report that is written will be giving to both parents.

Consent for evaluation and treatment.

Consent is hereby given for evaluation and treatment under the terms described in this consent document for _____ (name of minor) to be seen by _____ (name of therapist).

It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of the agreement.

At times in the course of treating a minor, we will hold sessions with a parent without the minor present. These sessions are for the purpose of gathering information that can be therapeutically beneficial to the client, and at times include parent psychoeducation as well.

By signing below you acknowledge that you understand and consent to these kind of sessions if it is deemed therapeutically beneficial to the client.

Your Name (please print): _____

Your relationship to the child: _____

I hereby swear that I have the following **legal custody**, and am willing to show paperwork to support this (circle appropriate): Joint Sole None

I hereby swear that I have the legal right to obtain treatment for the above named child.

I have read, understand, and agree to the Confidentiality Statement, and the Court Statement.

I agree to abide by the terms/policies set forth in this document.

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature: Date

Full name of minor:_____ DOB _____

Payment Agreement

Living Hope Counseling
16421 N. Tatum Blvd. #124
Phoenix, AZ 85032
602-313-5713

The purpose of this form is to provide you an efficient way of payment, if you so choose. It is also set up for the purpose of payment toward missed appointments. I welcome any questions you may have before signing.

• By completing and signing this Payment Agreement, you are indicating that you understand and agree to provide a valid credit card number, with expiration date, for payment of future therapy sessions, appointments, or other agreed upon fees.

• Your signature indicates you understand that if you do not attend a scheduled appointment, your credit card will be charged the regular cost of the session you reserved unless you canceled at least 24 hours in advance, business days Monday through Friday; for cancellations with less than 24 hours notice, the full service fee will be charged. For missed appointments with no notice given, the full fee will be charged.

• Your signature indicates you understand that you, not an insurance company or any other 3rd-party payer, will be paying for any missed or late cancelled appointments.

• Payments or co-payments are expected at the time of service or in advance of service, unless otherwise agreed upon. Your signature indicates you understand that if you do not pay with cash or check at the time of service, your credit card will be charged for your payment due. • Please note that we welcome Visa or Master Card; when using credit or debit card payments, a $4.00 surcharge will be added to each card transaction.

Current Fees for Services:

Initial Assessment/Evaluation	$150.00
Individual Therapy – 50 to 60 minutes	$150.00
Individual Therapy – 75 to 90 minutes	$210.00
Individual Therapy – 110 to 120 minutes	$285.00
Marital and Family Therapy – 50 to 60 minutes	$150.00
Marital and Family Therapy – 75 to 90 minutes	$210.00
Marital and Family Therapy – 110 to 120 minutes	$285.00
Letter and report writing – 50 min	$65.00

Please enter the following information exactly as it appears on your credit card statement:

I understand and agree to comply with this Payment Agreement. I authorize the use of my credit card information for payment of services rendered.

Client/ Guardian:_____

Sign:_____Date:_____ Print Name_____
Signature Client Name:_____ Day Phone: _____ CELL_____

Please enter the following information exactly as it appears on your credit card statement

Please Circle: VISA / MASTER CARD Card Number:_____
Expiration:_____ Card Verification Number:_____ Billing Zip Code:_____
Address:_____ _____
*Your credit card information will be held confidential and this information will be secured in your client file.