Intentional Counseling Grand Rapids LLC

781 Kenmoor Ave SE, Suite C. Grand Rapids, MI 49546

Also known as "Counseling at Health for Life Grand Rapids"

616-200-4433 Office Manager, Paul Krauss Paulk@healthforlifegr.com

(Staff are referred to as Paul Krauss MA LPC, his associates and interns)

Informed Consent for Treatment

☐ I am completing this consent for treatment for myself.

Name _____

☐ I am completing this consent for treatment for a minor child.

Name _____

Child's Name _____

Welcome! I look forward to working with you. I know that starting therapy is a major decision and you may have many questions. The purpose of this document is to inform you about what you can expect from me and to give you the opportunity to give your consent for various aspects of the therapeutic process. Please feel free to discuss any questions you have during our first session or at anytime.

By signing this document you are acknowledging that you have read and understand all of the information in the Informed Consent document and consent to receive services from Intentional Counseling Grand Rapids LLC. _____**(initials)**

I acknowledge that my counselor's biography information is available on the website and that I am able to ask for information about their degree, training, and background information at any time—and can be provided this both verbally and in writing. _____(initials)

Please mark the corresponding box for what you are agreeing to participate in. You are required to read the entire document, agree, and then sign in order to participate in therapy services with Paul Krauss, MA, LPC, his associates or interns.

☐ I want consultation services only.

☐ I choose to participate in therapy services with Paul Krauss, MA, LPC, his associates or interns:

☐ As an individual ☐ As a family

☐ I give permission to Paul Krauss, MA, LPC, his associates or interns to provide

therapy services to my minor child. *Both parents must sign, for me to provide services to anyone under 18 years of age.* _____**(initials)**

□ I give permission to_____ (Associate or Intern Name) to provide therapy services to my minor child. *Both parents must sign, for me to provide services to anyone under 18 years of age.* _____**(initials)**

_____**(initials)** I understand that participating in these services is voluntary and collaborative, and that I may end services for my child or myself at any time. I agree to verbally advise Paul Krauss, MA, LPC, his associates or interns when I decide to terminate services. I understand that, unless otherwise contracted, no contact for 90 days may result in file closure. My file may be reopened upon agreement by both parties.

_____ **(initials)** I understand that I will be participating in individual, group, couples, or family therapy services to address issues and concerns that I will share with my therapist. I understand that the focus of these services is on helping me reach my individual/couple/family goals. I understand that therapy often results in positive outcomes. However, there are no guarantees that these services will make me or my partner/family members feel better or resolve all of my problems, issues, or concerns. I also understand that the counseling process can open up levels of awareness that are painful (e.g. I could feel upset, anxious, angry, and/or uncomfortable. I may have to face difficult decisions about people, places, or things) in order to feel better.

_____ **(initials)** I understand that, while a competent practitioner of a variety of therapeutic approaches, Paul Krauss, MA, LPC, his associates or interns may choose to not provide couples counseling because of their own personal and clinical reasons. If Paul Krauss, MA, LPC, interns or associates choose to provide significant other and me with couples counseling, I understand that this is unique to our therapeutic relationship and that it is being done with best clinical care possible.

_____ **(initials)** I understand that my client record will be kept confidential, and that confidentiality includes all aspects of the topics discussed within the therapeutic setting. I also understand that, by law, there are limitations to confidentiality in cases when one or more of the following occur: **Intent to commit suicide; Intent to commit homicide; Any other act or intention to act in a way that may be a danger to self or others; Information regarding child or elder abuse/neglect that mental health providers are mandated by law to report; A court subpoena for records; Information regarding unprofessional conduct by another behavioral health professional. In addition, I understand that my therapist is justified in informing an identifiable third party of risk of contagious/fatal disease or potential harm.**

_____ **(initials)** I understand that my therapist may consult or seek supervision from a colleague when it is required or deemed necessary, in order to ensure quality care. I understand that my identity will be protected.

_____ **(initials)** I understand that in order to provide me with the best possible care, my therapist periodically tapes (audio or video) part or all of a therapy session. These tapes are for his professional development and will be destroyed as soon as he reviews them privately or, when deemed necessary to further the treatment, with the help of a colleague from whom he is seeking consultation. I understand that my identity will be protected and that I will always be informed before any taping is done. I may be given specific information about the consultant or supervisor he may use to help her review the session.

_____ **(initials)** I understand that I have a right to request a copy of my record in writing and that I will be billed for this service. I understand that I also have the right to sign a written authorization that will allow Paul Krauss, MA, LPC, his interns and associates to give and/or receive information verbally and in writing with individuals or entities that I designate.

_____ **(initials)** I understand that I have the right to participate in treatment decisions, including the development of my treatment plan. My therapist will work with me to determine the recommended services based on my situation; however I have the right to refuse treatment and to withdraw my informed consent for treatment by providing a written request. I understand that if I submit this request, Paul Krauss, MA LPC, his associates or interns will no longer be able to provide me with services.

_____ **(initials)** I understand that Paul Krauss, MA, LPC, his associates or interns and associates has the right to terminate services with me, whether for therapeutic or personal reasons. I understand that should this occur, I will be provided with information on how to obtain alternative therapy services (i.e. referral to another therapist or treatment provider).

_____ **(initials)** I understand that the therapy relationship is exclusively therapeutic (e.g. It is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions). I understand that the purpose of these boundaries is to ensure that you (therapist) and I (client) are clear in our roles for treatment and that my confidentiality is maintained.

_____ **(initials)** A pattern of canceled or missed sessions may be indicative of problems in commitment to therapy and will be addressed in session. Missing or canceling three sessions within a 90 day period may result in termination of services. Late arrivals will end on time.

_____**initials)** If we see each other accidentally outside of the therapy office, I will

not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

(PLEASE INITIAL OR CIRCLE ONE OPTION ABOVE)

_____ **(initials)** I understand that Paul Krauss, MA, LPC, his associates or interns will attempt to return my calls within 24-48 hrs (unless they are out of the office for a predetermined time period, which will be indicated on by their out of office voicemail message). I understand that Paul Krauss, MA, LPC, his associates or interns' office phone line are NOT emergency numbers. In the event of a crisis, I agree that I will call a crisis line in my area, or I will call **Crisis line at** 1-800-273-8255. In the event of an emergency, I agree that I will call **911** or to go to the closest emergency room.

○_____ (initials) I understand that Paul Krauss, MA, LPC, his associates or interns will attempt to return my call within 24-48 hours.

○_____ (initials) I understand in the case of an emergency that I will immediately call 911, or go to the nearest emergency room or urgent care clinic.

○ _____ (initials) I understand that if at any time I have a plan to hurt myself, or become suicidal or homicidal I will immediately do the following: Call 911 or Call The NATIONAL SUICIDE HOTLINE NUMBER at 1-800-273-8255.

_____ **(initials)** I understand that I am financially responsible for any and all charges incurred for the treatment of myself or the above-named client. I understand that I am held liable for any balance due on this account and that this balance will be due and payable on demand. I further understand that overdue accounts, with my name on them, may be submitted to a collection agency.

_____ **(initials)** I understand that therapy session's range in cost between $120/hr. - $150/hr unless we have agreed upon a sliding scale price. I understand that Paul Krauss, MA, LPC, his associates or interns have a set sliding scale with a fixed number of sliding scale appointments available. Intentional Counseling Grand Rapids LLCwill do our best to accommodate me, but if we cannot, we will provide you with appropriate referrals.

_____ **(initials)** I understand that a therapy hour is approximately 53-55 minutes long; longer or shorter sessions will be billed in 15-minute increments. Other professional services (e.g. telephone sessions or coaching sessions lasting longer than 10 minutes, report writing, coordination with other professionals, preparation of

records or treatment summaries) will be billed at $95/hr. in 15 minute increments. Legal services (e.g. court appearances) and associated travel time will be billed at $150/hr. Intentional Counseling Grand Rapids LLC reserves the right to change our fees with 30 days written notice.

_____ **(initials)** I understand payment is due at each counseling session. If I am utilizing insurance, the payment will be due at the beginning. We may decide it is a better arrangement to take the payment before each session. I may pay by cash, check, or credit card. Returned checks will be assessed a processing fee of $35.00.

_____ **(initials)** I understand that if I am utilizing insurance, Advantage Billing LLC or Simple Practice LLC will be processing payments and filing insurance claims on my behalf. Advantage Billing LLC will keep your identity confidential. If you have questions about your insurance benefits or claims questions, please call your insurance provider first. If you cannot resolve the issue, you may request contact information for Advantage Billing or Simple Practice LLC.

_____ **(initials)** I understand that Advantage Billing LLC or Simple Practice LLC will automatically send me a bill for any balance due. I understand that Advantage Billing LLC or Simple Practice LLC will automatically continue sending me a bill every 30 days thereafter or more or less frequently until the balance due is paid. I understand that Advantage Billing LLC or Simple Practice LLC may send my unpaid medical bill to a collections agency if it is not paid within three months, unless agreed upon with Paul Krauss, MA, LPC, his associates or interns and Advantage Billing LLC or Simple Practice LLC and myself.

_____ **(initials)** I understand that in the event that I do not provide Paul Krauss, MA, LPC, his associates or interns with at least a 48-hour verbal notice (by phone call or voice message) of appointment cancellations or miss an appointment, I am responsible for a late cancellation or no show fee and will be sent a bill or my credit card will be charged.

_____ **(initials)**If I am utilizing insurance the fee will be $80.00 for missed appointments and late cancellations.

_____ **(initials)**If I am a cash paying client, then I will be charged my regular session fee for missed appointments or late cancellations

_____ **(initials)** To cancel an appointment, call your counselor directly or at 616-200-4433. Do not send an email or text to cancel an appointment. Or call your associate or intern counselor.

_____ **(initials)** I understand that Paul Krauss, MA, LPC, his associates or interns will have me complete a credit card authorization form. I understand that my credit

card may be charged if I do not provide at least 24-hour verbal notice of an appointment that I am going to miss an appointment or if I do not provide 24 notice of a need to reschedule. If I do not come to my appointment my credit card may be charged or I will be sent a bill.

_____ **(initials)** I understand that Paul Krauss, MA, LPC, his associates or interns do not text message with any patients. In fact, Intentional Counseling Grand Rapids, LLC's phone is set up to not receive any text messages. I understand that calling via phone is the only acceptable way to cancel my appointment. I understand that calling via phone is the only reliable and acceptable way of communicating to Paul Krauss, MA, LPC, his associates or interns. I may send emails to Paul Krauss, MA, LPC, his associates or interns if I want to express my feelings. However, I understand it is not permitted to email Paul Krauss, MA, LPC, interns or associates if I am in crisis, feeling suicidal, or expecting a timely response. I must call the crisis line or 911 as agreed upon above. I may call Paul Krauss, MA, LPC, his associates or interns to let them know about a crisis only after I have followed the protocol of calling a crisis line or 911 and the crisis has subsided. I understand that Paul Krauss, MA, LPC, his associates or interns see many patients and are not generally available for crises. I may call Paul Krauss, MA, LPC, his associates or interns in attempt to schedule an extra weekly appointment I feel that I want this—but this appointment is not a replacement for utilizing crisis resources.

- _____ (initials) I understand that Paul Krauss, MA, LPC, his associates or interns are not responsible for *receiving, or responding to* any text messages that I send to Paul Krauss, MA, LPC, his associates or interns.

- _____ (initials) I understand texting is not a secure form of communication and I understand that by texting Paul Krauss, MA, LPC, his associates or interns that there is a chance that my private information is at risk, and therefore Paul Krauss, MA, LPC, his associates or interns are not liable for any compromised information that occurs as a result of texts sent.

_____ **(initials)** I understand that email messages may not be read in a timely manner and that emails are not considered a secure and private mode of communication. I agree not to hold Paul Krauss, MA, LPC, his associates or interns liable for any emails sent or received. If I choose to communicate by email I understand that there is no guarantee that email is a secure form of communication.

_____ (**initials**) I understand emailing is not a secure form of communication and I understand that by emailing Paul Krauss, MA, LPC, his associates or interns that there is a chance that my private information is at risk, and therefore Paul Krauss, MA, LPC, his associates or interns are not liable for any compromised information that occurs as a result of emails sent.

_____ (**initials**) I agree that Paul Krauss, MA, LPC and Intentional Counseling Grand Rapids LLC will not be held legally responsible for the actions of an intern or associate toward a client or client's family. The intern or associate themselves and their liability insurance provider will be held liable for any actual or alleged misconduct of negligence on the part of the intern or associate.

_____ **(initials)** I understand that Paul Krauss, MA, LPC, his associates or interns may be out of the office several times a year, usually for one week at a time, but occasionally for several weeks at a time. I understand that he will provide me with ample notice and a referral to a covering therapist during those times, if I request this.

_____ **(initials)** I agree that by signing on the line that I have read the entire document and agree to everything that is written in this document.

_____ **(initials)** I acknowledge and agree that I have read and understand all of the information in the Informed Consent document and consent to receive services from Paul Krauss, MA, LPC, his interns or associate.

Future questions, concerns, or clarifications can be addressed directly with Paul Krauss, MA, LPC, his associates or interns.

Signature:_____Date

Signature of second person:_____Date

If **Consent to Treat a Minor**

I/We, the parent(s) or guardian(s) of _____ have read and understand the above information and have discussed all aspects of informed consent with Paul Krauss, MA, LPC, his associates or interns.

I/We consent that _____may be treated as a client by Paul Krauss, MA, LPC, his associates or interns .

Signature of parent/guardian:_____Date

Signature of parent/guardian:_____Date