HERITAGE
FAMILY COUNSELING SERVICES

6525 E Mainsgate Rd
Wichita, KS 67226
(316) 461-7923
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Informed Consent
Agreement for Therapeutic Services

As a client(s) or parent of a client, you and/or your child have certain rights and responsibilities. Those rights and responsibilities are outlined below. Each family member (13 years and above) in the client family should read and initial each blank on this form. Signing this form indicates acceptance of these terms for provision of services:

____1) You have the right to ask questions about your therapy. Your clinician will explain his/her therapy approach and methods used if you would like. Your clinician will also discuss the Code of Ethics under which he/she practices if you desire.

____2) You or your clinician have the right to end therapy at any time without any moral, legal or financial obligations other than those already incurred. We request that if the decision is made to terminate, that a final session be scheduled to explore the reasons for termination. If a final session is not scheduled, your clinician may contact you to request feedback regarding termination. Termination itself can be a constructive and useful process. If a referral is desired, it will be made at this time.

____3) You have the right to specify and negotiate therapeutic goals and to renegotiate when necessary.

____4) You have the right to be fully informed about fees for therapy and the method of payment required.

____5) In order to communicate with insurance panels, it may be necessary to contact and share information regarding diagnosis, type of contact, frequency and duration of sessions with your specific provider.

____6) You have the right to confidentiality within certain limits. Information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency with the following exceptions:

a) you sign a written release of information indicating informed consent to such release;
b) you express serious intent to harm yourself or someone else;
c) there is evidence or reasonable suspicion of abuse against a minor child, elder person or dependent adult;
d) a subpoena or other court order is received directing the disclosure of information (it is our policy to assert privileged communication in such a situation);
e) you are in therapy or being tested by order of a court of law (the results of the treatment or test ordered must be revealed to the court); and
f) case consultation between the clinician and his/her clinical peers.

____7) You understand that suicide risk is to be taken very seriously. You want help in finding new ways to manage stress in times of crisis. You realize there are no guarantees about how crises resolve, and that your clinician is making reasonable efforts to maintain safety for everyone. You understand that in some cases hospitalization may be necessary.

____8) You have the responsibility to provide us with accurate information as to how we might best help you and to keep us advised of your needs throughout the therapeutic process.

____9) In working to achieve the potential benefits of therapy, it may require that you make firm efforts to change and it may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well relationship changes that may not be originally intended.

____10) Appointments are scheduled for 50 minutes, known as a "clinical" hour. The remaining 10 minutes on the "clock" hour is used by your clinician to maintain your file. Clients are expected to keep appointments as scheduled. **Because the appointment time is reserved for you, it is necessary to charge for appointments which are not canceled 24 hours in advance.** unless in fact they are occasioned by circumstances which we would both define as an emergency. You the client will be solely responsible for the full cost of the canceled or missed session. If you must cancel or reschedule, notify the clinician as far in advance as possible.

____11) You understand that all information is confidential according to HIPAA (Health Insurance Portability and Accountability Act) standards. Reception of HIPAA privacy practices and acknowledgement including verbal discussion of HIPAA expectations has taken place according to your initials.

____12) You understand the scope of practice of the assigned clinician. Discussion of your clinician's experience and scope of practice as well as inability to perform surgery or prescribe medicine has taken place according to your initials.

____13) You understand that in case of your clinician's death or incapacity to personally contact you, your clinician has identified (**to be filled in by clinician)**_____at _____to have confidential access to properly contact you to either close and store your case file and/or to offer referral services to ensure continuity of care.

____14) Per the BSRB (Behavioral Sciences Regulatory Board) we are required to request permission or waiver to contact your primary care physician in order to consult with regard to your treatment received and related medical needs.

_____waive_____or authorize to contact _____

Physician's Name/Number

____15) You understand that electronic communication through unencrypted text messages or email is not secure. It is our policy to not discuss therapeutic issues at length via text or email.

____16) I authorize my clinician to communicate with me via text at this mobile number: _____

OR to communicate with me via email at this address: _____

Client/Guardian Signature	Date	Client Signature	Date
Client/Guardian Signature	Date	Client Signature	Date
Clinician Signature	Date		