Juanita Mitchell, LMHC, CPT

4317 E. Genesee Street ♦ Suite 105 ♦ Syracuse, NY 13214 ♦ (315)569-1968

Informed Consent for Treatment

Thank you for choosing this office for your counseling needs. I am committed to giving you the best care possible. This form is to acquaint you further with the procedures and policies of my office and allow you the opportunity to give consent if you agree to the policies.

Client/Counselor Relationship
You and your counselor have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only a therapeutic aspect, rather than a social one. Know that sometimes counseling may cause feelings (i.e. anger, sadness, guilt, etc.) around personal issues to come to the surface. These feelings may cause you to feel embarrassed or uncomfortable talking about yourself. However, these risks are outweighed by the fact that counseling should help you feel or act better in the long run, as well as, help you to learn some new, important, and helpful things about yourself and others. The hope is you will also learn some new and better ways of handling your feelings or problems and come to feel better about yourself. If for some reason your counselor or you determine that other services might be more appropriate for you, I can assist you in finder another provider to meet your needs. You will then be responsible for contacting and evaluating the alternate providers.

Appointments
Appointments are typically scheduled on a weekly basis for children who are receiving Play Therapy. For adolescents and adults, weekly sessions are utilized until healing is underway and rapport is established, at which time, sessions may be moved to a bi-weekly basis. If you need to cancel an appointment, I ask that you call at least 24-hours in advance, whenever possible. If you do not call and do not give a 24-hour notice, you will be charged $45 for late cancellation or “no show”. Please note this is not a billable service to an insurance company and therefore is the responsibility of the person responsible for payment of the account.

Counseling Fees
Counseling fees are based on the type of session and length of session that I bill for (which will be discussed at the time of your initial intake appointment). Play therapy sessions typically are billed for a 30 minute rate ($60). I also bill for 45 and/or 60 minute sessions (which are typical in length for adults, adolescents, or family sessions). These rates range from $90-$115 depending on the amount of time and whether it is an individual or family session. Outside face-to face office work (such as inpatient visits, school conferences, school hearings and other collaborative meetings are charged at a rate of $65 per hour. I have separate fees for any court proceedings (see court policies form). There is no charge for emergency phone contact and phone calls that are 20 minutes or less. Calls that exceed 20 minutes will charged an hourly rate of $65 (which will be pro-rated accordingly if less than an hour).

Payments/Insurance Filing
Payments of fees (including any required co-pays or deductibles) are expected at the time of service. As a service to you I contract with O’Brien’s billing service to submit claims for you if you are using insurance benefits with a managed health care company that I am a participating provider with (or one that will reimburse for my services as an out-of-network provider). Insurance companies, managed care, and other third-party payers are given information that they request regarding service to the client. Information which may be requested includes types of services, dates/times of services, diagnosis, treatment planning, description of impairment, progress of therapy and summaries. By signing this form, you are also agreeing to let us use your PHI (Primary Health Information) and to send it to others for the purposes described above. If your claim is denied by your insurance, you will be responsible for payment of services provided. Payments can be made with cash or check. A fee of $30 will be charged for any returned checks. Defaulted accounts may be sent to collections. If an attorney is hired to collect the outstanding balance, the client agrees to pay all costs and any reasonable attorney feels incurred. By signing this form, you are also agreeing to let us use your PHI (Primary Health Information) and to send it to others for the purposes described above.

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Informed Consent for Treatment

Consenting for treatment of a minor child

Support of a child's caregiver(s) is essential. The general goal of involving children in counseling is to foster a therapeutic relationship at their developmental level. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be a part of overall development, they may not be the best goals for counseling. I will evaluate and discuss the interventions that seem most suitable for your situation with you. Also, because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law (see Court Policies form). Matters involving custody and mediation are best handled by another who is specially trained to perform a custody evaluation, rather than the child's counselor.

For the health and well-being of all children it is important that you do not bring sick children to the playroom. Please do not bring your child if they have a fever or if it has not been 24 hours since the fever broke. I also want to inform you that the toys are cleaned on a regular basis and I may ask children to use hand sanitizer sometimes during or before sessions. You can also be helpful by washing hands before they come to the playroom or using the wipes in the waiting room. I give permission for my child to use the hand wipes and/or hand sanitizer in this office ____________.

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children have some privacy in speaking with their counselor, the benefits of establishing a therapeutic relationship in counseling may be lost. Therefore, it is necessary to work out an arrangement in which children feel their privacy is generally being respected, while at the same time ensuring that parents have access to critical information. As a clinician, I use my best clinical judgment in revealing information to parents that I feel will best help and protect your child(ren).

The following circumstances can override the general policy that children are entitled to privacy, while parents and/or guardians have a legal right to information. Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the counselor is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible. Secondly, any evaluation, treatment, or reports ordered by or done for submission to a third party such as a court or school are not entirely confidential and will be shared with that agency with your specific written permission. Please note that this office does not have control over the information once it is released to a third party upon your request.

Name of minor child to receive treatment

____

Date of birth of minor child

____

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Consent to Treatment

To assist me in caring for you and/or your child(ren) please sign the form below to give your consent to receive counseling services at this time.

I (print name), ____, the undersigned, hereby attest that I have voluntarily entered into treatment for myself, ***or*** give my consent for the minor listed above (under the age of 18) or person under my legal guardianship, to receive treatment in counseling with Juanita Mitchell, LMHC, MS, CAS . Further, I consent to have treatment provided by this counselor in collaboration with her clinical supervisor(s). The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party and that it is recommended that this decision be discussed with the treating counselor to help facilitate a more appropriate plan for discharge.

Client signature (if adult client) ___________________________________ Date _________________

Parent/guardian signature ____ Date _________________

Relationship to minor child_______________________________________ Date _________________

Counselor____ Date _________________