Center Point Counseling Illinois, Inc.

Informed Consent

Client understands that while therapy may be beneficial, as with any treatment, there are inherent risks. During treatment, client will discuss personal issues which may bring up uncomfortable emotions such as anger, guilt, and sadness. The benefits of treatment can far outweigh this discomfort and can lead to benefits such as improved personal relationships and reduced feelings of emotional distress. Client acknowledges, however, that no warranty or guarantee can be made as to the results of therapy. Client hereby agrees to engage in treatment and/or psychotherapy with therapist at Center Point Counseling and understands the limits and policies explained below.

CONFIDENTIALITY: The discussions between client and therapist as well as any records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to client. No information will be released without clients written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following: clients become a danger to self or others, therapist becomes aware of any real or suspected abuse of a child or a protected adult who has been abused, neglected or financially exploited (in which case we are mandated reporters of the State of Illinois), if therapist receives a properly issued subpoena accompanied by a court order to produce records or attend court, a negligence suit brought by the client against the therapist, or the filing of a complaint with the licensing or certifying board. If client has any questions regarding confidentiality, they will bring them to the attention of their therapist. By signing this Information and Consent Form, client is giving consent to the undersigned therapist to share confidential information with all persons mandated by law and with the agency that referred client and the insurance carrier responsible for providing clients mental health care services and payment for those services. Client also releases and holds harmless the undersigned therapist from any departure from my right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If therapist believes that client is in physical or emotional danger to self, or that client is a danger to another human being, client understands that the therapist is required by law to contact medical or law enforcement personnel to prevent harm to self or another person, and may contact the person in danger.

CONSENT TO TREATMENT: Treatment and/or psychotherapy as stated, including the possible risks, complications, options, and expectations have been explained to client or clients representative and consent for treatment is thus given as noted by signature. Client is

voluntarily agreeing to receiving mental health assessment, treatment and services, and client understands that they may stop such treatment or services at any time. Client further understands that for counseling to be successful, their commitment to the process is essential.

FEES AND INSURANCE: client understands that the hourly fee is $160 for individual sessions and $175 for couples and family sessions. Telephone consults up to 15 min are free if not overused, and anything over 15 minutes will be charged to client directly at $40 per 15 min time period. Client understands that the therapist will verify insurance benefits if client chooses to use this, and that all fees not covered by insurance are the responsibility of the client. If client chooses not to use insurance they will be billed the hourly fee mentioned above at time of service. Client further understands that they will be expected to provide a credit card to be store with Center Point Counseling and this will be charged for their part of the session.

NO-SHOW AND CANCELATION POLICY: Client understands that their appointment is their reserved time and that Center Point Counseling requires 24-hours notification of cancelations. Client will be charged $100 for any appointment not canceled in this time period and for a no-show. This will be charged to client directly and not covered by insurance.

AGREEMENT: I have read and understand the above statements on service, policies and procedures. My signature below indicates that I give my full consent to receive services at Center Point Counseling Illinois, Inc.

Client Signature (age 16 & over) _____ Date _____

Client Signature (age 12-15) _____Date_____

Client Guardian (for minors) _____ Date _____

Printed Name of Client/Guardian signing _____

Provider signature _____ Date _____