



INFORMED CONSENT FOR COUNSELING

General Information: The relationship between a counselor and client is highly personal and, at the same time, a contractual agreement governed by government healthcare regulations. It's important therefore to understand how our relationship will work and what each of us can expect. This consent form will provide a framework for our work together. Because mental health issues are often complex, I want every client to understand the mutual guidelines of treatment. Many of the situations described below may never apply to you, but I want you to be informed just in case. Feel free to discuss any of this with me.

PLEASE READ THE INFORMATION BELOW CAREFULLY AND INDICATE THAT YOU HAVE REVIEWED THIS INFORMATION AND AGREE TO IT BY SIGNING AT THE END OF THIS DOCUMENT.

Confidentiality: The content of our sessions and all materials relevant to your treatment will be held confidential unless you request in writing to have all or portions of such content released to a specifically named person/persons. In the case of couples, family or group counseling, I will only release information after each session participant has waived his or her confidentiality in writing. In certain extreme circumstances, I may be required by law to disclose information to others without your consent. Even in these situations, I would attempt to address the issue with you and discuss the best path forward. The following list describes scenarios that may require such disclosure:

1. If I have reason to suspect that you pose an imminent risk of harm to yourself or others and I'm not able to work with you to ensure your safety or their safety.
2. If you disclose information about the abuse or neglect of a legal minor or a vulnerable adult such as someone who is elderly or disabled.
3. If a judge issues a court order requiring the release of your counseling records. If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential between you and me.

I may occasionally consult about your case with other professionals in their areas of expertise in order to provide the best treatment for you. This might include other counselors on staff at The Foundation Counseling Center. In such situations, I would only discuss the information necessary to receive helpful insight and input about potential resources. All professionals consulted would be bound to the same standards of confidentiality as I am. Your clinical records remain my property during and after your treatment. They will be maintained in a secure location for seven years after our final session, at which time they will be destroyed (according to Chapter 491 of Florida State Law).

Worldview and Values: The Foundation Counseling Center is a ministry of The Connection Church and as such, the counselors hold a Christian worldview and associated values in conjunction with The Connection Church Statement of Faith and Values. These views will naturally inform my counsel and conversations because my Christian worldview is foundational to our counseling model. You are free to hold and express your own views about life and spirituality.

The Counseling Process: You've taken a significant step by deciding to seek counseling. The outcome of your treatment depends largely on your willingness to engage in this process, which may result in emotional discomfort. During the counseling process, many clients discuss painful circumstances or memories that lead to distressing feelings. I invite you to inform me if any part of therapy becomes uncomfortable so I can attempt to make helpful adjustments. Along the way, I will answer any questions about the counseling process to the best of my ability. I will respect your decision to disagree with my input, decline my suggestions and terminate our counseling relationship at any time. If you have an administrative or clinical complaint, you agree to express this complaint to me directly by telephone or in writing so we can seek resolution. While I cannot promise that your feelings, behaviors or circumstances will change, I do promise to support you and strive to help you to the best of my ability. I will only provide treatment if I consider myself competent to address your issues and lack any personal conflicts that might hinder my ability to care for you. I reserve the right to refer you to another counselor who might be better equipped to help you. I also reserve the right to terminate treatment with you if I deem it ethically or clinically necessary. If such a situation occurs, I will discuss the situation with you and present you with treatment alternatives.

Contact Outside Counseling Sessions: Counseling treatment consists primarily of individual, in person sessions. I understand that difficult situations arise, so I will try to be available for occasional, brief phone conversations or text/ email exchanges to address issues or questions that can't wait until our next scheduled appointment. I don't provide crisis care, so you should first call 911 in the event of a psychological or physical emergency. If you think you may require significant care outside of scheduled sessions, you agree to inform me in a timely manner so we can make appropriate alternative arrangements. In order to provide the best care possible, I don't maintain social relationships with existing clients (this includes connecting on social media). Because social interaction can complicate the counseling process, such parameters are standard practice for counselors. If we happen to end up in regular contact outside the office due to mutual involvement in church or community activities, we'll discuss the situation and find a resolution we're both comfortable with. In order to protect your privacy, I will not approach you if we happen to see each other outside of the counseling office unless you've given me permission ahead of time. I don't want to put you in a situation where someone might ask how we know each other. You are welcome to approach me, however, and I'll gladly have a brief conversation with you. If others are present, I will not acknowledge that I'm your counselor unless you do so first.

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

DIGITAL AND AUDIO RECORDING

I hereby authorize The Foundation Counseling Center to record by audio and video all interactions held within the Foundation Counseling Center Office for supervisory and security purposes (security cameras). I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken, or if this form has been used to obtain insurance coverage for services provided. This authorization is fully understood and is made voluntarily on my part.

I hereby authorize that I will NOT record any audio or video during my session (whether in-person or via Telehealth) without first informing my therapist AND obtaining consent from my therapist. Lack of compliance with this policy could lead to immediate termination of the current sessions.

NO SHOW/CANCELLATION POLICY

Individual appointments are reserved exclusively for you and are considered confirmed at the time they are scheduled. Your counselor wishes to provide their best care during this time set aside for *you*.

In order to best serve our clients and respect our counselors, we require a minimum of 24 hours notice for rescheduling or canceling an appointment. This gives us enough time to possibly replace a client for this appointment time.

If a session is canceled less than 24 hours prior to the session time, that will be considered a Late Cancellation.

A \$25 fee will be charged for Late Cancellations.

If a client does not provide notification and does not show up for the scheduled session, that is considered a No-Show.

A \$35 fee will be charged for No Shows.

These fees will be charged to your credit card on file or will be collected with your next payment if there is no card on file.

To assist you, The Foundation Counseling Center attempts to provide courtesy reminder calls or texts on the business day before scheduled appointments. The system also offers text and email appointment reminders. However, in the event that clients do not receive a reminder, clients are *still* responsible for their upcoming appointments.

BY SIGNING HERE, YOU AGREE THAT YOU HAVE CAREFULLY READ AND REVIEWED THE INFORMATION PROVIDED IN THE DOCUMENT ABOVE, YOU FULLY UNDERSTAND ITS CONTENTS INCLUDING THE RISKS AND BENEFITS OF THE PROCEDURE(S) AND THAT YOU HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED TO YOUR SATISFACTION.

Client's Signature:

Print Name: _____ Date: _____

Signature: _____ Date: _____

If Client is a minor, legal guardian's signature:

Print Name: _____ Date: _____

Signature: _____ Date: _____

If you are a Couple attending counseling sessions together, second Client's signature:

Print Name: _____ Date: _____

Signature: _____ Date: _____