Kristen Eldridge, MEd, MC
Licensed Professional Counselor
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INFORMED CONSENT & CONSENT FOR SERVICES

This document indicates your rights as a client, including important information about HIPAA (a federal law that pertains to your Protected Health Information or PHI) as well as a set of mutual expectations regarding your therapy. This information has been provided to protect you, so please read carefully.

Privacy, confidentiality, and records. Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statutes. The most common of these exceptions are when there is a real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved. There are also numerous other circumstances when information may be released to comply with other federal, state or local laws; at which time we will discuss these releases with you if possible.

I also participate in a process where selected cases are discussed with other professional colleagues to facilitate our continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods.

I maintain an ongoing record of your treatment. It is kept in a locked cabinet to protect your confidentiality. You have the right to see this record and/or have a copy of it at your expense for $30 administrative fee (does not include mailing expenses if incurred). If you wish to see your record, please submit to me a written request and payment. If this practice is terminated or sold, please check the website at www.kriseldridgelpc.org for updated information to contact an identified designee to locate and access records.

Records are retained for six years after the last date an adult client received professional service from Kris Eldridge, LPC. If a client is a minor, records are retained the later of: three years after a child client's eighteenth birthday or six years after the last date of professional service. Records are stored in a locked filing cabinets in a secure area in the therapist's office. Records are disposed of after the stated period of retention are shredded and/or incinerated.

Financial responsibility. The fee for an initial consultation is $150. Following this initial consultation, therapy rates are $125 for a one 50-minute therapy session. Your signature below indicates that, in return for services provided to you by Kristen M. Eldridge, LPC, you will pay the agreed upon fee(s) for service(s). A $35 fee will be charged for checks returned for insufficient funds. A fee will be charged for letter(s) or report(s) written on behalf of the client.

Availability of Services. My practice does <u>not</u> have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the 9-1-1 or to local hotlines (EMPACT 480-784-1500; Crisis Line 602-222-9444). Established contacts with urgent need may contact me, but an immediate response is not guaranteed. A quick response in one situation does not imply a commitment of rapid response in other situation.

Appointments. Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve 50-60 minutes for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. **You will be financially responsible for appointments you fail to cancel in accordance with this policy. Please initial you have read and understand this policy._____**

Electronic communications. It is important to be aware that computers, cell phones, and email in particular are vulnerable to unauthorized access. Please notify me if you decide to avoid or limit in any way the use of any manner of electronic communication such as email, cell phone calls and/or texts, and/or faxes. Otherwise, if you do communicate any confidential or private information through these means, you have made the decision to take the risk these communications may be intercepted.

Legal Proceedings. In the unfortunate circumstance of divorce, custody and civil litigation, a client may desire to request my services to assist them in these matters. You can expect that I will NOT make recommendations, testify or get otherwise involved in the legal proceedings. It is an inherent conflict of interest for a treating professional to also offer evaluations and opinions in legal matters.

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Our relationship. The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially including, but not limited to, connecting on social media. The purpose of these boundaries is to ensure that we are both clear in our roles for your treatment and that your confidentiality is maintained.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it and if you feel the situation remains unresolved, you may contact the Board of Behavioral Health Examiners. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues, as well.

Purpose, limitations, and risks of treatment. Counseling, like most endeavors in the helping professions, is not an exact science. The ultimate purpose of counseling is to reduce your distress and help foster desired change, through a process of assessment, exploration and interventions. Due to the very nature of the work, there are no guarantees that the treatment provided will yield positive or intended results. I do emphasize that your investment in the counseling process will be to your overall benefit. Attempting to resolve issues that brought you to counseling may bring to the surface various emotional and psychological pain and symptoms. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss and seek to resolve family issues. Sometimes a decision that is positive for one family member can be viewed negatively by another family member. Our intention is to assist your family and the individuals in it towards healing.

Treatment process and rights. Your counseling will begin with one or more sessions devoted to an initial assessment so that we can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal. Also, I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for the counselor's skill or experience.

Consent for evaluation and treatment. Consent is hereby given for evaluation and treatment under the terms described in this consent document. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

My signature acknowledges I have read and understand the information provided in this document and agree to abide by its terms during our professional relationship.

Client #1 Signature:_____ Date: _____

Client #2 Signature:_____ Date: _____

Therapist Signature:_____ Date: _____

In the case of a minor child, please specify the following:

Full name of minor:_____ DOB _____ Relationship: _____

Therapist Signature:_____ Date: _____