

Connections Counseling, LLC

Date: _____

Name: _____

Address: _____

Employer: (the employer will NOT be contacted)

For Children-School/Grade: _____

Home/Cell Phone Number: _____

Do you give your permission to leave a message at this number? _____

DOB: _____

SS #: _____

Email Address: _____

Do you give permission to contact you via email for appointments? _____

Names & Ages of People Living With You:

Who will participate in therapy?

Are there any firearms in the home? _____

Who referred you? _____

Telephone Number of Referral Source: _____

Do you give permission to contact this person? _____ (a formal permission letter to release/receive records would be provided for doctor/lawyer or other provider referrals)

*Participation in therapy is a voluntary process. All information is confidential unless any member is assessed by the therapist to be a threat to harm to self, others, or property. Payment is due at the end of each 50-minute session. **The charge of the session is rendered if 24 hours notice is not given for cancellations.** By signing below, each participant has read and agreed to these terms.*

Connections Counseling, LLC
Informed Consent and Confidentiality for Mental Health Counseling

Prior to receiving mental health treatment and/or counseling you, as the Client and or Client's guardian, have the following rights to be fully informed as to:

1. the nature of the proposed treatment and any reasonable treatment alternatives
2. the training, credentials, and licensure of your Counselor
3. truthful disclosure of reasonably foreseeable benefits, risks, and hazards of the proposed treatment, alternative treatments and of not doing anything
4. the right to fully withdraw consent for treatment at any time

You also have the right to the confidential treatment of information about you and/or minor child. Information maintained in your Client record will not be released to anyone outside the direct therapeutic relationship without your approval under the Federal HIPPA guidelines unless required by law such as the mandatory reporting of suspected child/elderly abuse or neglect, duty to warn to prevent harm to others, and in the event of dangerousness to self, others or property due to a mental disorder etc., in the event of legal proceedings against the Counselor/Practitioner, disclosure as mandated by Third Party payment requirements, or, under specific circumstances, a court subpoena.

By providing your signature to this document, you attest that you, as the Client and/or Client's legal guardian, have:

1. Discussed these issues with your Counselor and without reservation provide your consent for treatment.
2. The legal right to provide consent for mental health treatment and are competent to make decisions regarding the course and/or discontinuation of treatment.
3. Received a copy of the Mental Health Bill of Rights.
4. Agreed to the policy that 24 hours cancellation notice prior to a scheduled appointment is required or you will be held responsible for the full fee.

Client(s) Name-Printed	Client(s) Signature	Date
Guardian Name-Printed	Guardian Name-Signature	Date
Counselor Signature	Date	

Connections Counseling, LLC Risks and Benefits of Counseling

The practice of Counseling is defined as follows:

The application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.

Adopted by ACA Governing Counsel, October 1997 / Adopted by NBCC Board of Directors, November 1997

Benefits of Counseling: Research indicates that most people who engage in counseling benefit from the experience. Counseling provides the person with the opportunity to talk and learn about themselves and their problems in a safe, non-judgmental, caring environment. Counseling can impact and improve relationships with significant others. The benefits from counseling may be an improved ability to relate with others; a clearer understanding of self, values, goals, increase productivity in work, school, and relationships; and an improved ability to deal with everyday stresses. Counseling may help relieve the stress and impaired functioning associated with trauma, grief and mental disorders.

Risks of Counseling: The risks associated with the counseling process may include remembering unpleasant events and may arouse strong feelings, and as an outcome may result in ill advised or risk taking choices/behaviors. The risks also include continuation of presenting problems, increased feelings of loneliness, sadness, depression, anxiety, feelings of hopelessness or suicide. Counseling for relational issues may result in the growth of only one partner and/or the decision to end the relationship. There may be other risks as well.

Counseling is a relationship and you have the right to discuss your concerns about the risks associated with the progress of counseling with your counselor at any time. Signing this agreement implies that the under-signed have read and agreed to the policy's intent and have discussed any concerns with the counselor prior to the beginning of the counseling relationship.

Client's Name

Client Signature

Date

Counselor's Name

Counselor's Signature

Date

Connections Counseling, LLC
Professional Ethical Standards

American Association for Marriage and Family Therapy (AAMFT) Code of Ethics

Excerpt: "1.2 Marriage and family therapists obtain appropriate informed consent to therapy or related procedures as early as feasible in the therapeutic relationship, and use language that is reasonably understandable to clients. The content of informed consent may vary depending upon the client and treatment plan; however, informed consent generally necessitates that the client: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When persons, due to age or mental status, are legally incapable of giving informed consent, marriage and family therapists obtain informed permission from a legally authorized person, if such substitute consent is legally permissible."

American Association of Christian Counselors: Code of Ethics

Excerpt: "Christian counselors secure client consent for all counseling and related services. This includes the video/audio-taping of client sessions, the use of supervisory and consultative help, the application of special procedures and evaluations, and the communication of client data with other professionals and institutions. Christian counselors take care that (1) the client has the capacity to give consent; (2) we have discussed counseling together and the client reasonably understands the nature and process of counseling; the costs, time, and work required; the limits of counseling; and any appropriate alternatives; and (3) the client freely gives consent to counseling, without coercion or undue influence.... Christian counselors respect the need for informed consent regarding the structure and process of counseling. Early in counseling, counselor and client should discuss and agree upon these issues: the nature of and course of therapy; client issues and goals; potential problems and reasonable alternatives to counseling; counselor status and credentials; confidentiality and its limits; fees and financial procedures; limitations about time and access to the counselor, including directions in emergency situations; and procedures for resolution of disputes and misunderstandings. If the counselor is supervised, that fact shall be disclosed and the supervisor's name and role indicated to the client."

National Board for Certified Counselors: Code of Ethics

Excerpt: "8. When counseling is initiated, and throughout the counseling process as necessary, counselors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be performed, and clearly indicate limitations that may affect the relationship as well as any other pertinent information."

For additional codes of ethics, please see the appropriate licensure board for the therapist's credentials.

Client's Name

Client Signature

Date

Counselor's Name

Counselor's Signature

Date

Connections Counseling, LLC
Policy Concerning Fees for Service

The arrangement of the fee for therapy is a private issue discussed and agreed upon by you and your Counselor. Connections Counseling, LLC requires the full payment of the fee during the therapy session for when the service is provided.

Connections Counseling, LLC accepts payment for services only in cash or checks. Credit Cards are not accepted at this time. At the time of payment, a receipt for the service can be provided which includes the information typically required from managed care and insurance providers.

Connections Counseling, LLC will provide you with the receipt for service if you wish to submit to your managed care and insurance providers for out-of-network reimbursement. Connections Counseling, LLC does not process insurance reimbursements and any efforts to collect reimbursement is considered the sole responsibility of the Client and/or Client's guardian.

Appointments scheduled between you and your Counselor represent a mutual commitment to the therapeutic relationship and process. Missed appointments may be detrimental to the therapeutic relationship and process and may be considered an issue of therapeutic concern. As such, 24 hours notice must be provided by you to cancel a scheduled appointment. You may call either the main number or your Counselor's cell phone. Both numbers will be provided to you.

If you do not provide 24 hours cancellation notice you will be billed for the missed appointment. Payment will be due at your next scheduled appointment. Failure to resolve fees due to missed appointments becomes a therapeutic issue and will be discussed between you and your Counselor. As you make payment arrangements for missed appointments with your Counselor, your therapy schedule will not be interrupted and you will not be discharged due to financial reasons. Your Counselor may need, however, to discuss treatment options with you including referral to a more appropriate level of care.

As a matter of mutual respect, your time is also valued and so if your Counselor misses or cancels an appointment without 24 hours prior notice to you then you will be offered a therapy session without charge!

Please discuss any concerns regarding the above issues with your Counselor. Your signature acknowledges your receipt and consent of this policy.

Thank you and Welcome to Connections Counseling, LLC.

Client(s) / Date

Counselor / Date

Connections Counseling, LLC
**Authorization for Use or Disclosure of Information to Other Therapists
Within Connections Counseling, LLC**

I request and authorize _____ (name of therapist) to both release and receive information from other therapists within Connections Counseling, LLC. Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc. (If all information is acceptable, simply write "ALL")

This protected health information is being used or disclosed for the purpose of continuity of care and fluidity in treatment for a team approach. Additionally, this information is being used for the purpose of therapist supervision and quality improvement.

I understand and agree that the information I am authorizing to be released may include:

- (1) Mental health information
- (2) Process and content of sessions
- (3) Dates of sessions and demographic information

Unless otherwise requested below:

This authorization shall be in force and effect until: (Please complete one of the following)

Expiration of Authorization Date: _____ (Insert Expiration Date)

The happening of the following expiration event:

I understand that, as set forth in Connections Counseling Privacy Documents, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Connections Counseling, LLC
38 Cooper Street
Woodbury, NJ 08096

By signing below, I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that the practice will not condition my treatment on whether I provide authorization for the requested use or disclosure. I understand that I have the right to inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)

Connections Counseling, LLC

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

Signature of Client or Guardian/Date

Print Name of Client or Guardian

Client Date of Birth

Signature of Connections Counseling, LLC Witness

Print Name of Witness

