Metro Counseling Center
Healing the Brokenhearted

Cindy Eldridge, MA, LPC, NCC, GRS, RPT
1201 NW Briarcliff Parkway Suite 200 Kansas City, MO. 64116
Telephone: 816-590-0700 Email: metrocounseling@att.net

INFORMED CONSENT & THERAPY CONTRACT

I feel it is important that you are fully informed about the services you will be receiving before deciding to begin counseling. Your signature below indicates that you have received, read, and understand the practice policies of this counseling site. Please initial all sections below to which you agree. Any sections not initialed will be discussed prior to treatment.

_____ I understand that the counselor is bound by the Code of Ethics set forth by the American Counseling Association (ACA). I can request a copy of these ethics at any time.

_____ **The Therapy Process:** Any time you seek therapy to work on your personal struggles or relationship difficulties there are benefits and risks involved. The benefits can include the ability to handle or cope with your specific concerns and/or your interpersonal relationships in a healthier way. You may also gain a greater understanding of personal, interpersonal, or family goals and values. This new understanding may lead the way to greater maturity and happiness as an individual, couple, or as a family. There may also be other benefits that come as you work at resolving your specific concerns.

However, therapy can be challenging and uncomfortable at times. Remembering and resolving an unpleasant event may cause intense feelings of fear, anger, depression, and frustration. As you work to resolve personal issues or issues between family members, marital partners, and other persons, you may experience discomfort and an increase in conflict. There may be changes in your relationships, which you had not originally anticipated.

Your therapist will discuss with you the benefits and risks involved in your particular situation. We encourage you to discuss any concerns you have as you progress with your therapist.

_____ **Confidentiality:** I am dedicated to preserving the confidentiality and privacy of all my clients. Some state and federal laws require that I disclose information in certain situations. ***Please review the following situations in which I must breach confidentiality:*** 1) to warn others and proper authorities of life threatening concerns should it become necessary, 2) to notify appropriate state agencies of any suspicion of child abuse/neglect or dependent, elderly or disabled adult abuse or neglect, 3) to provide information in legal cases when under court order, 4) to release information from my files when the client requests this using a written release; 4) if a client should bring charges against the therapist. 5) I may share your information with another professional in order to get an objective viewpoint. Any professional I consult with is required to maintain your confidentiality. Also, in my absence, (vacation time, or unexpected out of town travel) if another therapist fills in, I may release your information to another therapist who will serve on call should an emergency a rise. Should a client record their session, I will/cannot protect your privacy or guarantee confidentiality and will not be held liable for any shared information in any form.

_____**TELEPHONE ACCESSIBILITY:** If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room. All phone calls past 10 minutes will be charged the hourly fee in 15-minute increments.

_____**SOCIAL MEDIA AND TELECOMMUNICATION:** Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on the Facebook social networking site. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

_____**ELECTRONIC COMMUNICATION:** I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via **email** or **text messaging** for issues regarding scheduling or cancellations, I will do so. (Look, I'm good at many things but know that texting is not my strong point and you will find errors in my texts. ☺) While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. VSee video sessions (HIPPA compliant) are available.

_____ **Sessions:** Research has shown that the nature and severity of the client's presenting problems usually determine the length of therapy. Treatment can range from a few sessions to several months of therapy. The estimated length of your treatment will be determined in a collaborative discussion between you and your therapist. Regular reviews of your progress and continuing need for therapy will be discussed with you. You may leave therapy at any time, but I ask that you agree to discuss the termination of therapy with your counselor in a regular therapy session, rather than by phone. I usually conduct evaluations and collect assessments, which can last through the first 3 sessions. During this time we will have an opportunity to decide if I am the right therapist for you. When psychotherapy begins I will schedule one session per week at a time we agree on, although some sessions may be longer or more frequent. Each counseling session is 45-50 minutes and includes the time needed to schedule another appointment and receive payment. **Payment is required whether you are present for your appointment or you are absent, cancel or are a "no show".** If you cancel three appointments, we'll discuss issues that may indicate the need for another therapeutic plan.

_____ **Consultation:** If you may benefit from a treatment I cannot provide, I will give you referrals in order that you may receive that treatment. I will discuss the reasons for any additional recommendations I have so you can decide what is best.

_____ **Court & Subpoenas:** If your records are requested through subpoena, you will be notified in writing and provided with a copy of the subpoena. You must then provide the therapist with a written objection to the subpoena or indicate that an objection will be filed with the court (with a copy to the therapist). It is the client's responsibility to file this with the court within the time frame legally allowed. **The therapist will not serve as a witness in custody disputes or provide records for such matters.** By signing and/or initialing this paragraph you agree to accept this policy. If you go to court you will need to receive an evaluation from another professional for those involved. I will provide a summary, if necessary, but not actual records to the court. The charge for this service is $350.00 per hour of preparation and must be paid in advance. If required to attend court proceedings the fee will be $350.00 per hour with two-hours payable in advance plus the cost of any attorney fees. Court proceeding fees can be avoided if cancellation is made two weeks in advance.

_____ **Treatment of Minors:** Persons under the age of 18 must have permission of the parent/legal guardian to receive therapeutic services. Parents will be involved in treatment as I deem necessary while maintaining confidentiality to the minor except in cases of dangerous drug use, suicidal ideation, running away, abuse/ threat of abuse and/or harm to self or others. 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. I will want both parents involved unless rights have been terminated or severed or it is just not feasible to do so.

_____ **Insurance:** I do not accept insurance, however, if you belong to a plan that pays for out of network services, documentation will be provided in order for you to request reimbursement.

_____ **Fee Policy:** Payment is expected at the time of service. After the first hour you will be billed in 15-minute increments should you choose for the session to run over. A sliding scale fee can be offered. The agreed upon rate for your session is $_____ per session. **Metro Counseling Center requires you to have a card on file so your session can be paid for without taking up your counseling time.** Your counselor will bill your card on the day of your session. If you are paying by check, please have your check made out in advance payable to Metro Counseling Center and hand it to your counselor at the beginning of the session. There will be a $60.00 charge on all returned checks. If you need to speak with me between sessions you may call me. All calls past 10 minutes will be charged the hourly fee in 15-minute increments. **If you do not show for a session or you cancel your session you will be charged for the full session. Your counselor will attempt to reschedule or conduct a phone or HIPPA compliant VSee video session for that week if you are unable to attend in person.**

_____ I have received a list of resources and phone numbers to be used in emergency situations. This information has been explained to me and any questions answered by my counselor.

_____**TERMINATION:** Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued. Should you fail to call or show up for your scheduled sessions two weeks in a row without notice, I must consider the professional relationship discontinued.

My signature below indicates that I give my full informed consent to receive counseling services and that I/we agree to all initialed policies above.

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

_____ Date: _____

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