LaVerne Kalafor, Ed.S, LCSW , CCHt

Counseling and Consultative Services LLC

INFORMED CONSENT

Thank you for choosing my counseling services. Today's appointment will take approximately 45 – 60 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of the policies, State and Federal Laws and your rights.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for:

a) Information shared with your psychiatrist or designated physician/ARNP noted here:

   ____ (phone/fax)_______________

b) information (diagnosis and dates of service) shared with your insurance company to process claims,
c) information you and/or your child or children report about physical or sexual abuse; then I am obligated to report this to the Department of Child and Protective Services,
d) where you sign a release of information to have specific information shared,
e) if you provide information that informs me that you are in danger of harming yourself or others,
f) information necessary for case supervision or consultation and,
g) when required by law.

If an emergency situation for which the client or their guardian feels immediate attention is necessary the client or guardian understands that they are to contact the emergency services in the community (911) for those services. I will follow those emergency services with standard counseling and support to the client or the client's family.

FINANCIAL/INSURANCE ISSUES:

As a courtesy I will bill your insurance company, responsible party or third party payer for you if you wish. I ask that at each session you pay your copay fee (if applicable). If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you may be billed $25.00. I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

CONSENT FOR TREATMENT:

I/we undersigned consent psychotherapeutic evaluation and treatment. I authorize any representative from Counseling and Consultative Services LLC, to leave messages or texts at any of my phone numbers listed. I authorize the release of any medical or other information necessary to process this claim.

For consent for treatment for minors: I/We consent that ____ be treated as a client by LaVerne M. Kalafor, Ed.S. LCSW, CCHt at Counseling and Consultative Services LLC.

Signature(s): ____

Date: _____________________ Phone: _______________________________