FAMILY STRATEGIES
COUNSELING CENTER

CLIENT CONSENT - Please READ and SIGN

(Revised 9/28/2020)

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If your counselor is required to communicate to another about your case, you must give written permission to do so. The only exception is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm, or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide. Insurance companies are entitled to diagnosis, date, and type of service. All therapeutic services conducted will adhere to the laws of the state of Arizona and the Arizona Board of Behavioral Health; we are licensed within the state of Arizona and assert that services are being provided within the state of Arizona where the therapist resides and is licensed to practice.

INFORMED CONSENT

Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While the therapist will use best effort to assist you, there can be no assurances of results, and no promises can be made regarding the outcome of any service provided. You should question the rationale of any service, intervention, and discussion if these seem unclear to you. Your signature below indicates that you understand that there are risks for noncompliance with treatment recommendations, and that you will discuss these risks with your therapist.

E-THERAPY (i.e. TELEMEDICINE, TELETHERAPY, CYBERTHERAPY, etc.)

There are limitations and risks associated with e-therapy, including inherent confidentiality risks of electronic communication and potential for technology failure. If there is an emergency and the therapist is unavailable, you should call 9-1-1. If video is not available, the therapist will ask for identification. You will also be asked about your physical location during the telemedicine encounter, as well as verification that the setting provides for your confidentiality.

CLINICAL SUPERVISION

Your therapist _____is under clinical supervision as an associate licensed counselor with the Arizona Board of Behavioral Health, or is a University intern studying for a Masters Degree, and provides therapy under the clinical supervision of Floyd Godfrey, LPC, or Kim Buck, LPC who are qualified to provide supervision within the state of Arizona according to the laws and regulations set forth by the Arizona Board of Behavioral Health. You can contact any of the above mentioned supervisors by calling 480-668-8301.

LITIGATION LIMITATION

The clinicians at Family Strategies Counseling Center, LLC are not trained for court reporting and testifying nor do they specialize in forensics. If you become involved in legal proceedings that require mandated participation by your therapist, you will be expected to pay for all professional time, including preparation and transportation time and costs, even if called to testify by another party regarding your case. Your therapist is not a court advocate and would be legally required to speak truthfully under oath. We highly recommend seeking outside counsel from forensically trained professionals with situations requiring court interaction, as we typically do not testify in court except under mitigating circumstances or court orders.

PAYMENT & MISSED APPOINTMENTS

Payment is expected at the time services are rendered, by cash, check or credit. If you are unable to keep an appointment, please notify your counselor as soon as possible. If an appointment is canceled or missed **without 24 hours prior notice, you will be billed at regular session fees.**

FINANCIAL RESPONSIBILITY

You (or responsible party) are considered responsible for payment of professional services. When you request to bill a third party, such as an insurance company, and that third party fails to make payment within 30 days from the date of billing, the client or responsible party is expected to pay within 10 days of receipt of the statement. Bills not paid within 30 days from the date of billing will be subject to an interest charge of 10% of the outstanding bill.

INFORMED CONSENT

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form, I acknowledge that I have both read, understood and that I agree to all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me. I also acknowledge that I have received a copy of **"Client Rights"** and **"Complaint/Grievance Procedures"** as well as the **"Notice of Privacy Policies – HIPAA"** documents.

_____ _____ _____

(Client Signature) **(Print Name)** **Date**

_____ _____

(Therapist Signature) **Date**

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I, _____ _____ am the parent or legal guardian with legal custody

(Parent/ Guardian Signature) **(Print Name)**

of_____, and give permission to FSCS to provide counseling services for my child.

(Child Printed Name)