Jennifer Hill, LPCC
Licensed Professional Clinical Counselor
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INFORMED CONSENT FOR TREATMENT:
COUPLES THERAPY

Counseling: We understand that couples therapy begins with an evaluation of our relationship, past and present. We understand that because of the commitment and the potential impact on us, it is important to make an informed choice when selecting our counselor. We agree to share responsibility with our counselor for the therapy process, including goal setting and termination. By entering into couples therapy, we accept that we both understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes one or both of us makes will have an impact on our partner and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify potential effects of changes.

Confidentiality: Information obtained during counseling sessions will not be disclosed to any outside persons or agencies without your written permission, except when required by law:

1. reasonable suspicion of abuse of children or elderly persons
2. client(s) present a serious danger of violence to another
3. client(s) may be harm to him/herself unless protective measures are taken

We understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. We agree not to subpoena our therapist to testify for or against either party or to provide records in a court action. We have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with our counselor. We understand that while working as a couple, anything either of us might say individually, whether by phone or in an individual session, will be held confidential and will not be shared with the spouse/partner without the individual's consent. If we have any further questions regarding expectations of confidentiality, we can contact our counselor at (760) 458-1600.

_____ **(initial)**

Payment: We understand that as private paying clients, we are expected to pay at the time of counseling services by credit card, cash, or check. The standard fee is $80.00 per session, unless special arrangements have been approved. We agree to pay the agreed upon amount of $_____ for all services provided by Jennifer Hill at the end of each session. Any check returned for insufficient funds will be assessed a $35 fee. We understand that if we chose to pay with a credit card, then we must also pay 2.75% processing fee.

_____ **(initial)**

Insurance: It is recommended that you contact your insurance carrier to find out how much they pay for outpatient psychotherapy treatment. The amount of payment will depend on your policy. Many medical health insurance policies do cover at least part of the cost of outpatient psychotherapy. Keep in mind that if you are utilizing insurance funds, third parties may review your medical record to obtain information about diagnosis, treatment process and prognosis for the purpose of treatment authorization, quality care management and payment for services. As a courtesy service, depending on your particular insurance provider, your insurance may be billed. Payment is required at the time of service. You will be required to pay all fees not covered or denied by your insurance.

I understand my insurance will not be billed by my therapist and payment is due when services are rendered. _____ (initial)

I understand that payment is due when services are rendered and that a HICFA 1500 form will be given to me to file with my insurance company for reimbursement. _____ (initial)

I understand that my insurance will be billed. However, total payment is required at the time of service. The name of my insurance company is

_____

_____ (initial)

Appointments: Sessions consist of 50 minutes made in advance starting and ending on time. If we arrive late, the session will still cost full price and end at the pre-arranged time. Cancelations must be provided at least 24 hours prior to the scheduled appointment. We agree to pay $50 no-show fee if notice is not given within 24-hour timeframe. We will call Jennifer Hill at (760) 458-1600 at least 24 hours in advance and leave a message in order to avoid being charged. Lateness or cancellations made by the therapist will be rescheduled.

_____ **(initial)**

Please initial the following correspondence options to authorize Jennifer Hill for future communication regarding appointments, billing issues, or other pertinent information regarding my treatment.

☐ Voice messages at: _____

☐ Text messages at: _____

☐ Email messages at: _____

Email, texting, and other forms of internet-based communication are non-secure and non-confidential. If we send emails and texts to Jennifer Hill with a response requested, we are willing to accept the risks.

Emergencies:

In the event of an emergency call 911 or (888)724-7240. Jennifer Hill will answer telephone calls during business hours
(9:00am – 6:00pm) on weekdays and Saturdays until 5:00pm.

By signing below, we agree to the policies entailed on pages #1, #2, and #3. We also agree to accept mental health services from Jennifer Hill MS, LPCC and accept full responsibility for payment for such services.

_____ _____

Client #1 Signature Date

_____ _____

Client #2 Signature Date

_____ _____

Counselor Signature Date