HEALING LOGOS CHRISTIAN FAMILY COUNSELING, INC.

9567 Arrow Route, Unit P, Rancho Cucamonga, CA 91730

(909) 726-5042

"A Word in Season for the Weary"

INFORMED CONSENT

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information About Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Note: The therapist or counselor should indicate his/her licensure status before the client completes this form.

Your therapist/counselor is a:

- ☐ Licensed Marriage and Family Therapist
- ☐ Associate Marriage and Family Therapist
- ☐ Pastoral Counselor
- ☐ Life Coach

*If your therapist is an Associate Marriage and Family Therapist, his/her practice is conducted under the supervision of a licensed mental health professional. The clinical supervisor's name, license type and license number are listed below:

Name of Clinical Supervisor (if applicable)	License Type	License Number

Information About This Practice

The name of this practice is HEALING LOGOS CHRISTIAN COUNSELING.
The individual therapist who operate this practice is Gloria Haywood, LMFT, #104400.

Fees and Insurance

The fee for service is $ 110 per 50-minute individual or couple therapy session. * The

fee for service is $ 120 per 50-minute conjoint (family- 3+) therapy session.* The fee

for service is $ 40 per 1-hour group therapy session.

*(A sliding scale may be offered).

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

If you have insurance, please check with your insurance company to ensure that Healing Logos Christian Family Counseling, Inc., is part of their network. It is your responsibility to make sure you are eligible to be covered by Healing Logos. If Healing Logos is not a part of your insurance company, we can provide a Superbill for you to give to your insurance company. With a Superbill you will pay your therapist and submit the Superbill for reimbursement. Please verify in advance that your insurance company accepts superbills.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time. _____ Initial

Telehealth Counseling

The preference for therapy is face to face with the clients. However, it is not always convenient for clients to meet face to face with their therapist. Healing Logos offers telehealth which allows clients to receive the help they need in the privacy of their homes. Telehealth is limited to the state in which the therapist is licensed. There are benefits to telehealth. As with any communication through electronic media, there is a risk of confidentiality. Healing Logos does everything possible to minimize the risk of using telehealth. In signing your informed consent, you are stating that you have been made aware of the possible risk, and you choose to have your sessions using electronic media (mobile cell phone, computer, Skype, FaceTime or any other audio and visual electronic media). _____ Initial

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, our therapist will not disclose information communicated

privately to him or her by one family member, to any other family member without written permission). _____ Initial

Exceptions to Confidentiality

There are **exceptions** to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also be required or permitted to break confidentiality when they have determined that a client presents a serious danger of physical violence to another person or when a client is dangerous to him or herself.

If you choose to use an insurance company for your payment, be aware that you are also acknowledging and giving permission for that insurance company to review your records.

If you participate in marital or family therapy, the couple or family is the **unit of treatment**. Your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that your therapist utilizes a "No secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you. . _____ Initial

Minors and Confidentiality

Communications between therapists and clients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker. Minor clients and their parents are urged to discuss any questions or concerns they have on this topic with their therapist. _____ Initial

***** PLEASE BE ADVISED***COURT CASES**

Please be advised if there are custody issues and therapist is required to attend court, time outside of sessions are not covered by insurance, and the regular full hourly fee of $110 per hour will be charged. _____ Initial

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different quantity of therapy sessions depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. **In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours' notice in advance. If you do not notify therapist, you are**

responsible for the <u>full</u> payment for the missed session. Unexpected emergencies happen. In the event this happens please leave a voicemail as soon as you are aware you will miss the session and no charge will incur. Please understand insurance companies do not pay for missed appointments. Any missed sessions without proper notification will be your financial responsibility. _____ Initial

<u>Therapist Availability/Emergencies</u>

You are welcome to phone your therapist in between sessions. However, as a rule, it is our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during the therapist's normal workdays within 24 hours. You should be aware that your therapist is generally available to return phone calls within approximately 24 hours. Your therapist is not available to return phone calls after 7 p.m. Your therapist is not available to return phone calls on Sundays or Mondays.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message. **In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 9-1-1 to request emergency assistance.** Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

Please be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: (800) <u>SUICIDE (800) 784-2433 OR (800) 273-TALK (800) 273-8255</u>___

Youth Shelter: ( ) _____

Domestic Violence Help: (909) __<u>386-1647</u>_____

Hospital: ( ) _____

Other: ( ) _____

*Please check numbers frequently and update your personal list . _____ Initial

<u>Therapist Communications</u>

Your therapist may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

- ☐ My therapist may call me on my home phone. My home phone number is ( ) _____.
- ☐ My therapist may call me on my cell phone. My cell phone number is: ( ) _____.
- ☐ My therapist may send a text message to my cell phone. My cell phone number is ( ) _____.
- ☐ My therapist may call me at work. My work phone is ( ) _____.
- ☐ My therapist may communicate with me by e-mail. My e-mail address is: _____.___
- ☐ My therapist may send a fax to me. My fax number is ( ) _____.
- ☐ My therapist may send mail to me at my home address.
- ☐ My therapist may send mail to me at my work address.

Sensitive, clinical information is to be discussed over the phone or in personas deemed appropriate by the therapist. For appropriate e-mail or text communication therapist will respond to your email or text within 24 hours. **Potential risks of using electronic communication may include, but are not limited to; inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network.** E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. **You may be charged for time the therapist spends reading and responding e-mail or text messages.** . _____ Initial

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation; your therapist will provide recommendations to you regarding your treatment. We believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedbacks to you regarding your progress and will invite your participation in the discussion.

Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However due to the varying nature and severity of problems and the individuality of each client, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result. _____ Initial

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Our therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. _____ Initial

Your signature indicates that you have read this agreement in its entirety for services carefully and understand its contents. Please ask your therapist to address any questions or concerns that you have about this information before you sign.

NOTICE TO CLIENTS: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of **Marriage and Family Therapists**/Licensed Educational Psychologists/Clinical Social Workers/Professional Clinical Counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Name of Client (print)	**Name of Client (print)**
Signature	**Signature**
Date	**Date**

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