Stacy PERKINS, LCPC, Ltd.
licensed clinical professional counselor

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INFORMED CONSENT

I realize that starting counseling is a major decision and that you may have many questions. This document is intended to inform you of what to expect regarding my policies and procedures. If you have other questions or concerns, please ask and I will do my best to give you the information you need.

CONFIDENTIALITY: Confidentiality is taken seriously. As a client, you have a right to privacy. However, under certain situations, there are limits to confidentiality. In the event that a client gives information regarding the suspected abuse of a child, as a mandated reporter, I may be obligated to report such information to authorities. When a client is in danger of harming him- or herself or others, confidentiality may need to be broken to promote safety.

SESSIONS/CANCELLATION POLICY: Sessions are 45 or 60 minutes long, although the precise length may vary. The number and frequency of sessions is determined collaboratively. For successful therapy, regular and consistent sessions are recommended. ***If you need to cancel or reschedule an appointment, please do so 24 hours before your appointment by calling and leaving a voicemail message. Otherwise, you will be expected to pay the full fee for the missed session. Fees for missed sessions are expected, except in the case of an emergency. Insurance companies never pay missed appointment fees.***

FEES: Your initial 60 minute session is $160.00. Thereafter, the fee for 30-minute session is $80.00, 45-minute session is $130.00 and 60-minute session is $160.00. Telephone conversations, site visits, report writing and reading, consultation with other professionals, longer sessions, etc. will be charged at the same rate, unless indicated and agreed otherwise.

PAYMENTS AND INSURANCE: You will be expected to pay for each session at the time it is held, unless we agree otherwise. I currently accept cash, checks and credit cards (MC and Visa) as payment for services rendered. Should you have health insurance, I can assist you in verifying your coverage and file primary claims on your behalf. It should be noted, however, that you (not your insurance company) are responsible for full payment of fees, so it is important to confirm exactly what mental health services your insurance policy covers. *You must obtain authorization from your primary care physician or your insurance company prior to the first office visit if this is a requirement under your insurance plan.* Secondary insurance claim filing is your responsibility. I will make sure you have the necessary information to do that if needed. Failure to keep payments current may result in discontinuation of counseling services.

Please check below one of the two options below.

- ❑ I authorize Stacy Perkins, LCPC to act as my agent helping me obtain payment from my healthcare provider (name of carrier) _____. I also authorize the release of necessary information to the insurance company for the pursuit of payment. If my healthcare company changes, it is my responsibility to let Stacy Perkins, LCPC know immediately. If not, I will be responsible for payment of the balance on my account. I authorize insurance payments directly to Stacy L. Perkins, LCPC, Ltd.

- ❑ I do not authorize Stacy Perkins to contact my healthcare provider for 3rd party payment. FOR BC/BS PPO insured's: Regardless of the arrangement with BC/BS, I will pay the self-pay rate. If I decide to submit claims in the future, Stacy Perkins, LCPC is not responsible for services rendered as a private pay client.

TELEPHONE AND EMERGENCY PROCEDURES: Normally, we will discuss significant matters during session. If you need to contact me between sessions, please leave a voice mail message at 312.810.0707 and I will return your call as soon as possible. I plan to return calls promptly but at times may be unable to return calls as soon as you may require. In the event that I am unavailable in an emergency, go to the nearest local emergency room, or contact one of the following crisis intervention services: DuPage County: 630.627.1700; Kane County: 630.966.9393; you may also call 911, or call your primary care physician or psychiatrist.

COMMUNICATION: I authorize Stacy Perkins, LCPC to communicate with me in the following ways: (Please Check)

- ❑ Leave a message on my phone:
  - o Home _____
  - o Cell_____
- ❑ Communicate by Email_____
- ❑ Communicate by Text_____

Please Note: Any communication by phone, text or email are not expected to be in lue of therapy.

EMAIL AND TEXTING: I prefer using email and or texting to arrange and/or modify appointments or briefly check with clients. Please do not email or text me content related to your therapy sessions, as email and text are not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my internet service providers. While it is unlikely that someone will not be looking at these logs, they are, in theory, available to read by the system administrator(s) of

the internet service provider. You should also know that if I receive any emails or texts from you and any responses I send to you that involve any therapeutic information will become a part of your legal record.

The response time for text messages and emails is within 24 hours Monday-Friday. I do not return emails or texts over the weekend or on holidays. Emails and texts are **never** to be used in an emergency situation. If you need to reach me please call me at (312) 810-0707.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc... or experiencing anxiety, depression, insomnia, etc.. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

HIPPA: (Please Check)

- ❑ HIPPA: I understand, and have been given a copy of, the Privacy Notice as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the notice I do not understand.

CONCLUSION: (Please Check)

- ❑ I understand and have been given a copy of the Consent to Treatment form. I will ask for an explanation and clarification of any part of the information I do not understand.

I/We have read the above information and agree to these terms for the receipt of counseling services.

Signature _____ Date _____

Signature_____ Date_____

CONSENT TO TREATMENT FOR CHILDREN & YOUTH

When I work with children, especially those under the age of about 12, parents' questions about the therapy process will generally be answered. As children grow more able to understand and choose, they assume more rights. For those between the ages of 12 and 18, details discussed in therapy will be treated as confidential. However, adolescents will be encouraged by the therapist to share important information with their parents.

Consent for treatment of children or adolescents: I/We agree that _____

_____ may be treated as a client of Stacy L Perkins, M.A., LCPC, Ltd.

Signature _____ Date _____

Signature _____ Date _____