LifeSolutions Counseling Associates, P.C.
1185 W. Carmel Dr., Ste. D-4
Carmel, IN 46032
INFORMED CONSENT

Thank you for choosing LifeSolutions Counseling Associates, P.C. Today's appointment will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision, and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask. We will try our best to give you all the information you need. All our associates have obtained their clinical degrees from accredited universities, have extensive experience working with individuals and families and are licensed by the State of Indiana to provide mental health counseling. LifeSolutions therapists have developed strong reputations in the metropolitan area and keep abreast of evidence based practices in our field. We are strongly grounded in cognitive-behavior therapy due to its proven effectiveness but do modify our approach depending on the person and/or condition. We also adhere to a strength-based approach that dictates all treatment options, planning and implementation be done in a collaborative effort with you. Thus, treatment practices, philosophy and plan imitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with consultants, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information that is reported about neglect, or physical or sexual abuse of minors, elderly, or disabled individuals; (by Indiana State Law, I am mandated to report this) d) where you sign a release of information to have specific information shared, e) if you provide information that informs LifeSolutions that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and g) or when required by law. If an emergency situation for which the client and/or their guardian feels immediate attention is necessary, the client and/or guardian understands that they are to contact the emergency services at the nearest emergency room or call 911. LifeSolutions therapists will follow those emergency services with standard counseling and support to the client and/or the client's family. Please keep in mind that communications via email and text messages are not secure. Although it is unlikely, there is a possibility that information you include in an email or text message can be intercepted and read by other parties besides the person to whom it is addressed. Please do not include personal identifying information such as your birth date, or personal medical information in any emails or text messages you send to us.

- ○ **Please check this box if you would like us to communicate with you via email.**
  Email Address:_____

- ○ **Please check this box if you would like us to communicate with you via text message.**
  Phone Number:_____

Required signature(s)_____Date:_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician(s)

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____
Required signature(s)_____Date_____

FINANCIAL/INSURANCE ISSUES: By signing below, you agree to be financially responsible for all fees incurred while accessing services at LifeSolutions Counseling Associates, P.C. As a courtesy we will bill your insurance company, HMO, responsible party or third party payer if you wish. We do request that at each session you pay your fee in full by check or credit card. If your insurance company denies payment, we will help with any appeal process but you are ultimately responsible for fees associated with services at LifeSolutions. However, if your insurance does not cover charges incurred at LifeSolutions, you shall be responsible for all reasonable cost of the collection of this account, which may include but not limit to, client collection fees, late fees, rebilling charges, interest, reasonable attorney fees and court cost on any outstanding balance. If you need to cancel or reschedule an appointment, please give at least 24 hours advance notice so that your therapist can schedule the time for other clients waiting for open appointments. We do charge a $75 no-show rate if you do not notify us within 24 hours that you cannot make your appointment. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested. ***I agree to the financial arrangements listed in this sections and have a right to receive a copy of my fee schedule.***

Required signature(s)_____Date_____

If your account should be sent to collections, you agree in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at the numbers associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending a text message or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.
I/We have read this disclosure and agree that the Creditor may contact me/us as described above. I/We shall be responsible for all reasonable costs of the collection of this account, which may include but not limited to, client collection fees of 30%, reasonable attorney fees and court costs on any outstanding balance.

Required signature(s)_____Date_____

NOTICE CLIENT RIGHTS: I/We have read and received a copy of the Client Rights document. May we contact you at home (circle one) **yes no**? May we contact you at work **yes no?** May we contact you by cell phone **yes no?** Where may we contact you?

_____

Required signature(s)_____Date_____

CONSENT FOR TREATMENT OF SELF:

I, _____, consent to be treated as a client at LifeSolutions Counseling Associates, P.C. At times it may be necessary to schedule appointments during school/work hours. We ask for your cooperation to provide the timeliest treatment for you.

Signature(s)_____Date_____

OR (One signature is required)

CONSENT FOR TREATMENT OF MINORS OR ADULT UNDER LEGAL GUARDIANSHIP:

I/We consent that _____ may be treated as a client at LifeSolutions Counseling Associates, P.C.. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and/or your children.

Signature(s)_____Date_____