Varady Counseling Services, LLC
LICENSED PROFESSIONAL COUNSELOR

# Informed Consent

## TRAINING & CREDENTIALS

M.A. in Counseling from University of Missouri Kansas City

Licensed Professional Counselor in the state of KS - License # 2993

## CANCELLATION

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or cancellation of an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions. All messages, including cancellations, may be left on my voicemail: 913.735.0784

## PAYMENT & INSURANCE REIMBURSEMENT

I operate as a fee-for-service counselor, meaning that my services are paid for directly by the client without anyone arranging the fee for service but you, the patient, and me, the therapist. This arrangement allows the work to be directed more solely between the two of us. Unless prior arrangement is made between us, payment is expected at the time of service. Payment can be made by cash or credit card. Upon your request, I will provide you with a copy of your receipt, which you can then submit to your insurance company for reimbursement. Not all issues/conditions/problems that are the focus of counseling are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. If you desire to submit for reimbursement from your insurance company, you should also be aware that most insurance companies require therapists to provide them with a clinical diagnosis. Sometimes this requires me to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report submitted upon request.

Initial_____ Date_____

**CONFIDENTIALITY**

Information disclosed in sessions is considered confidential and will not be revealed to anyone without your written permission, except where disclosure is permitted by law and deemed to be in the best interest of the client. The following are the legally permissible exceptions to confidentiality:

1. When there is reasonable suspicion of child, elder or dependent adult abuse or neglect.
2. When the client presents a serious danger of violence to him/herself, others, or the property of others.
3. Pursuant to a lawfully issued subpoena.
4. With client written request and release of information.
5. In order to provide insurance with information about therapy.
6. Parents have a right to have a reasonable account of their minor child's therapy. Occasionally when a child/adolescent reveals information in therapy, they wish it to remain confidential. Usually their request will be honored unless it involves dangerous behavior such as drug/alcohol use, risky sexual behavior, suicidal ideation, or running away.
7. If you and your partner decide to have individual sessions as part of the couple's therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner.

On occasion I might talk about part of your case with another therapist or professional. The circumstances where I might do this are as follows:

1. When I am meeting with my clinical supervisor (see supervisor section) and my supervisory group. In this situation I will reveal the least amount of necessary information possible.
2. I sometimes consult with other therapists and experts pertaining to clients. This helps me provide high-quality treatment. These people are also required to keep your information private. You name will not be given, and they will only be told pertinent information in order to understand you situation.

Initial_____ Date_____

**Legal Issues, Testimony, Court Reports, Subpoenas**

If you become involved in a legal matter and I am requested to provide testimony, my hourly rate is $150 and includes all time out of the office (including travel time). Payment is due five business days in advance of the testimony. The charge will occur even if I do not testify unless given seven days' notice of the cancellation, as I was unable to schedule any clients during this time. Any time spent meeting with your attorney, corresponding, or preparing documentation or reports will also be billed at $150 per hour.

**Please note that it is my policy to not make recommendations about child custody.**

Notice: In the event that a subpoena for records or testimony is received, (1) the client will be notified and provided with a copy of the subpoena; (2) the client must either provide the practitioner with a written waiver of objection to the subpoena or indicate that an objection will be filed with the court (with a copy sent to the practitioner); and (3) if an objection to that subpoena is to be filed, it is the responsibility of the client to have it filed with the court.

**WHEN DISCLOSURE MAY BE REQUIRED**

Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the counseling records and/or testimony by your counselor. In couple or family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Your counselor will use his/her clinical judgment when revealing such information.

**COUPLES**

For the best possible outcome of couple's therapy, it is important that you understand the process and work involved in couple therapy. Couple's therapy starts with an assessment of your relationships both past and present.

Couple's therapy is about changing the "dance" you have co-created throughout your time together as a couple. By entering into couple's therapy, you agree to work towards changes that may involve experiencing difficult and intense feelings, some of which may be painful in order to reach our goals. Therapy will involve change on both person's parts.

Couple's therapy is a time for you to explore the issues that keep you from enjoying and growing in your relationship. There may be times when I appear to be on one or the other's side, but I am really on the side of your relationship. If you feel that I am siding unfairly with your partner, you need to bring up your feelings for discussion in therapy.

Initial_____ Date_____

At times it may be helpful for me to see one or both of us for individual sessions as part of couple treatment. I will not keep secrets. I will work with you individually, if necessary, to help you share information with your partner in order to further therapeutic goals. If one spouse chooses not to share significant information that impacts the couple relationship, then I may seek permission to share that information with the other spouse; if that permission is not given, then couple therapy may become unsustainable and I may have to terminate couple therapy.

If at the time when couple's therapy is terminated and either or both of you wish to re-contract with me for individual therapy, I will discuss re-contracting or referral options with each of you considering what is in your best interest at the time.

Phone calls and emails between sessions are only for making or canceling appointments and genuinely urgent matters.

Should it be necessary to release any information about couple therapy to a third party, both members of the couple must sign a release of information or information cannot be shared with anyone.

We understand that information discussed in couple's therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving either of the partners.

We agree not to subpoena our therapist to testify for or against either party or to provide records in a court action.

**EMERGENCIES**

If there is an emergency during our work together, or in the future after termination where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact the person whose name you have provided on the Client Information Form.

The therapist is not on call in between sessions. I will attempt to set a special counseling session if needed before the regularly scheduled time, but I cannot guarantee availability. If you experience an emergency outside of session I recommend calling 911 or going to your nearest emergency room.

**HEALTH INSURANCE**

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information

Initial_____ Date_____

will be communicated to the carrier. Your counselor has no control or knowledge over what insurance companies do with the information he/she submits or who has access to this information.

**YOUR RIGHT TO REVIEW RECORDS:**

As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice.

Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person that you specify unless I assess that releasing such information might be harmful in any way.

**TELEPHONE & EMERGENCY PROCEDURES:**

If you need to contact me for an urgent matter between sessions, please call 913.735.0784 and your call will be returned as soon as possible. If a life-threatening emergency arises between sessions, call 911 or go to the nearest emergency room. Calls of a non-urgent nature that are left for the counselor will be returned as soon as possible. Non-urgent telephone calls left for me during the weekend will be returned on the next business day. If an emergency situation arises, please indicate it clearly in your message. I cannot guarantee the lack of technology issues that prevent the receipt of messages.

**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 see 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 invite you to respond openly and honestly.

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. I may challenge some of your assumptions or perceptions or propose different way of looking at, thinking about, or handling situations which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you into therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended.

Initial_____ Date_____

Counseling may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member may be viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it can be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according to the problem that is being treated and my assessment of what will best benefit you. These approaches may include cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), emotion focused, narrative, and psycho-educational.

**DISCUSSION OF TREATMENT PLAN**:

Within a reasonable period of time after the initiation of treatment, I will discuss with you (the client) my working understanding of the problem, treatment plan, therapeutic objectives and view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be given a comprehensive answer. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

**LICENSURE & SUPERVISION**

A licensed professional counselor (LPC) refers to a person who is licensed by the Kansas Behavioral Sciences Regulatory Board and who engages in the practice of professional counseling. My counseling license guarantees that I have been trained and supervised as a professional counselor. As an LPC, I work under the supervision of Mary Ann Altenbernd, a licensed clinical professional counselor (LCPC phone # 913-645-6347) as an independent practitioner in order to obtain a further level of licensure. As a part of our agreement, you give permission for Ms. Altenbernd to have full access to your client file for the purpose of providing guidance and supervision. You further give permission for me to present your case during supervision with other counselors who are being supervised by Ms. Altenbernd . In such cases, only necessary information will be disclosed. and other counselors in supervision are bound by the same ethical obligations as myself and supervision sessions are kept strictly confidential with exceptions only as defined by KS state law. If you have any questions or concerns about my licensure and/or supervision please discuss them with me. On occasion I may ask you if we can video/audio record a session for supervision purposes. These recordings are erased immediately after use and are never sent electronically. I am happy to answer any questions you might have about this. If you agree to occasionally be recorded

Initial_____ Date_____

please indicate here: ____I agree to be video/audio recorded ____I do not agree to be video/ audio recorded

**TERMINATION**

After our first few meetings, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such cases, I will give you a number of professional referrals that you can contact. If at any point during therapy I assess that I am not effective in helping you reach your goals, I am obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the clinician of your choice in order to help with the transition. If at any time you would like another professional's opinion, or wish to consult with another counselor, I will assist you in finding someone qualified, and if I have your written consent, I will provide her/him with the essential information. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you may prefer.

**CONTACTING YOUR PHYSICIAN**

Under Kansas Law I am required to consult with your primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to any observed symptoms of a mental disorder. In order to complete such a consultation, I will request that you complete a Release of Information form. You may waive your right to my consultation with your physician. If that is your preference, please indicate so here: I wish to waive my right to this counselor contacting my physician: ____**Yes I waive my right** ____**No I do not waive my right**

**DUAL RELATIONSHIP**

Therapy never involves sexual or business relationships or any other dual relationship that could impair my objectivity, clinical judgment, therapeutic effectiveness or which can be exploitative in nature.

**ELECTRONIC COMMUNICATION**

You may communicate confirmation and/or cancellation of appointments through the use of email. Although unlikely, it may be possible for others to see information sent through email. I

Initial_____ Date_____

recommend careful consideration of any messages sent by way of email communication. Any information beyond confirmation and/or cancellation of appointments should be communicated either by phone or in person during your scheduled session. Having been made aware of the above-mentioned information, you (please place a mark in either the "do" or "do not" area)

**do _____ do not_____** give permission for me to communicate through email.

**I HAVE READ THE ABOVE. I UNDERSTAND AND FULLY ACCEPT THE CONDITIONS AS STATED IN EACH PARAGRAPH OF THIS CONSENT**.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Rebecca Varady, MA, LPC,