CORE COUNSELING

INFORMED CONSENT FOR COUNSELING AGREEMENT

Welcome and thank you for selecting Core Counseling Services for your mental health needs. This document contains important information about our professional services and business practices. Please read it carefully and note any questions you may have so we can discuss them. As a consumer of psychological services, you are entitled to be fully informed. When you sign this document, it will represent an agreement between us. If you are a minor, your parent or guardian should read and sign this form.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the client and the particular problems that you bring forward. There are many different methods we may use to treat the problems that you hope to address. Psychotherapy calls for very active effort on your part, involving a large commitment of time, money and energy. In order to be successful, you will have to work on things we talk about during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy often leads to better relationships, solutions to specific problems, and a significant reduction in feelings of stress. Though we expect therapy to be helpful, there are no guarantees of what you will experience. Feel free to discuss any concerns you may have during the course of treatment. You also have a right to seek a second opinion at any time.

INITIALS: ________

Treatment Sessions

During the initial consultation, we can decide whether I am the best person to provide the psychological services you need in order to meet your goals. The first few sessions are usually evaluative. If psychotherapy begins, I will schedule weekly sessions at a time we agree upon. Certain situations may warrant a modified schedule, such as twice weekly or biweekly. Sessions are scheduled as such until we agree that a different time schedule is appropriate. Goals for therapy are determined in the first few sessions, then are periodically reviewed and refined. Termination of therapy occurs when we mutually agree that your goals have been satisfactorily addressed or there is some other reason to terminate.

INITIALS: ________

Therapy and Medication

Physical symptoms are sometimes the result of emotional stress. They can be reduced or even eliminated under certain therapeutic conditions. It is important, however, to consult your medical doctor or nurse practitioner to review your current situation and to ascertain the degree to which your symptoms have a physical base. Depending on your symptoms, possible medications for psychological distress may be considered. Please inform me of any medications that your doctor(s) may prescribe. Your initials below will allow me to share information with your primary care physician and/or psychiatrist.

*INITIALS:*________

Confidentiality

The information presented in therapy is personal and confidential. All information between the therapist and the client is held strictly confidential unless:

1. The client authorizes the release of information with his/her signature.

2. The client presents physical danger to him, her, or themselves.

3. The client presents physical danger to others.

4. Child/Elder abuse or neglect is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken. In addition, by initialing below you are consenting to allow me to discuss your case from time to time in supervision with colleagues. While names are not routinely used, you need to be aware of the fact that I may seek consultation regarding your case. I believe this provides the best level of care.

*INITIALS:*________

Digital Security and Confidentiality

Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than in person. You are responsible for understanding the potential risks of confidentiality being breached through unencrypted email, lack of password protection or leaving information on a public computer accessible by others.

Other potential risks of breaching confidentiality could include messages failing to be received if they are sent to the wrong address. Confidentiality could be breached in transit by hackers or internet service providers or at either end by others with access to your account or computer. When accessing the internet from public locations you should consider the visibility of your screen to

people around you. Using cell phones can also be risky in that signals are scrambled but rarely encrypted.

I reserve the right to restrict the use of any copies or recordings you make of our confidential communications. Either party must ask permission before recording any portion of video sessions. Posting any portion of said sessions on internet websites is strictly prohibited.

***INITIALS:*________**

Emergencies

Core Counseling Services is an outpatient facility. Our clinicians cannot assume responsibility for clients' day-to-day functioning, as more intensive treatments are designed to do. It is the responsibility of the client to discuss expectations of after-hours care with the clinician upon intake so that, if necessary, an appropriate referral can be made. In the case of an emergency, when a client fears harm to himself/herself or another, please dial 911 or go to the nearest hospital emergency room. We are not an emergency facility.

***INITIALS:*________**

My signature below indicates that I understand these policies and I grant consent for Core Counseling Services to provide psychological services and counseling to myself and/or minor members of my family.

You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

I have read, understand, and agree to all of the above information.

Name (printed):_______________________________________Date of Birth: _______________

Signature:____Date:______________________

Parents of Minors

I understand the need for confidentiality between my child and his/her therapist. I understand confidentiality will be maintained unless the therapist determines that my child is a danger to him/herself or others, or when my child gives permission to share information with me.

Parent/Guardian Name (printed):________________________Date of Birth: ______________

Parent/Guardian

Signature:___________________________________Date:______________________

Form updated 2024 by Core Counseling Services, Co