INNER AWAKENING
Counseling & Consultation PLLC

POLICIES & CONSENT FOR TREATMENT

NAME OF CLIENT:_____ **DATE OF BIRTH**:_____

For minors, NAME OF PERSON COMPLETING THIS FORM_____

Relationship to the minor:_____

CONSENT FOR TREATMENT

I am electing to receive diagnosis and treatment from Inner Awakening Counseling & Consultation, PLLC for a suspected or confirmed mental or behavioral health problem which I am experiencing. I understand that services will be provided by credentialed staff who are authorized to provide mental and behavioral health care service in the State of West Virginia and who will provide services within their scope practice according to their license and will do so following established ethical guidelines of licensing and other credentialing bodies. **Initials:**_____

ATTENDANCE & CANCELLATION

To provide the highest quality care clients should make every effort to attend their scheduled appointments as agreed to in the collaborative plan of care. A 24-hour notice of cancellation is required. Clients who do not provide this notice will be held financially responsible for the session fee (insurance does not covered missed appointment fees). The missed session fee is $50 for an hour session, and $25 for a half hour session. Additionally, clients who miss two sessions and fail to cancel with the 24 hour advance notice may be discharged from service. In these instances referrals to other providers will be made available. If the therapist must cancel, every effort will be made to reschedule your appointment as quickly as possible. **Initials:**_____

PAYMENT FOR SERVICES

Payment for serves include self-pay and billing managed care providers (ie: insurance companies). Inner Awakening Counseling & Consultation, PLLC is not a participating provider with all insurance companies. Please confirm that your insurance is accepted prior to your first appointment. Clients whose insurance lapses, or are otherwise denied by their insurance provider, are still responsible to pay the full rate of service. Additional sessions will not be scheduled until fees are paid. **Initials:**_____

SIGNATURE ON FILE

If you seek reimbursement for services from your Health Insurance Company, please initial the following:

___ I authorize use of this form for my Insurance Companies.
___ I authorize release the minimal amount of information to my Insurance Companies as required for reimbursement.
___ I authorize payment directly to my provider of services.
___ I permit a copy of this authorization to be used in the place of the original.
___ I understand I am financially responsible for prompt payment of all deductibles and co-payments.

ETHICS & PERSONAL RELATIONSHIPS

The experience of working with a counselor can be a very personal and intimate experience for most people. Although your counselor may feel like a trusted friend, your counselor is a trained professional, and the working relationship with the client is, and must remain, professional. To that end, your counselor will not engage in personal relationships with their clients

outside of the clinical setting. This includes, but is not limited to, social encounters for non-clinical purposes, and interaction on social media. **Initials:**_____

EMERGENCIES

Inner Awakening Counseling & Consultation, PLLC is intended as an outpatient mental health provider. In the event of a real or suspected mental health emergency (eg: suicidal or homicidal intentions, hallucinations or delusions), do not call or come to our office but instead call 911 or go to the nearest hospital emergency room. **Initials:**_____

PRIVACY PRACTICES

I acknowledge that staff of Inner Awakening Counseling & Consultation, PLLC will use my information only for purposes of coordination of care and provision of treatment, and will guard against the unnecessary disclosure of my protected health information (PHI), and that my PHI will remain confidential unless, through explicit written consent, I give authorization for disclosure.

Limits to confidentiality

Federal privacy rules allow Inner Awakening Counseling & Consultation, PLLC to use or disclose your health information without your consent or authorization for the following reasons:

- When you are suspected to be an imminent danger to yourself or someone else.
- To report abuse or neglect of a child or a vulnerable adult.
- To an oversight agency when required for activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action.
- For law enforcement and legal proceedings when required with appropriate documentation, warrant, or subpoena is provided.
- When state or federal requires such a disclosure.

You also have the following rights:

- To received restricted communications.
- To inspect and receive a copy of your health records.
- To request an amendment of your health record when the record is factually inaccurate.
- To receive an accounting of any disclosures of your PHI that have been made.
- To request a copy of these Privacy Practice in writing.

I have read, understood, and spoken with my therapist regarding the policies above. Any questions I have regarding these policies have been addressed.

For minor clients: I affirm that I have the sole legal authority to give consent for the child listed above.

_____ _____

Name- print Signature/ Date

_____ _____

Reviewed by- PRINT Signature/ Date