

## INFORMED CONSENT

Thank you for choosing Angie Hoffman, LPC. Today's appointment will take approximately 45 minutes. Treatment practices, philosophy, plan limitations, and risks will be discussed with you today. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

This document is intended to inform you of my policies, state and federal laws, and your rights as a client. Please read it carefully. When you sign this document it will represent an agreement between us.

<u>CREDENTIALS AND EXPERIENCE</u>: I have earned a Bachelor of Science Degree in Counseling, a Master's Degree in Counseling, and post graduate certification in Play Therapy. I am certified by the State of Missouri as a Licensed Professional Counselor and by the Association for Play Therapy as a Registered Play Therapist-Supervisor. I have been in practice since 2011 and have clinical experience in treating children, adolescents, adults, and families.

<u>CONFIDENTIALITY</u>: Your verbal communication and clinical records are strictly confidential, and I am committed to do everything possible to guard any information that you share with me. However, there are times when I am legally required to share information with others. Some exceptions to confidentiality include, but are not limited to the following:

- 1. I may share information such as diagnosis and dates of service with your insurance company to process your claims;
- 2. If I am informed of alleged or suspected physical or sexual abuse, then, by Missouri law, I am obligated to report this to the Department of Children and Family Services;
- 3. If you or your parent/legal guardian provides a valid, written consent to release information to a third party;
- 4. If the parent/legal guardian of a client under the age of 18 requests information about the client, and if I determine, based on the policies included in the Child Therapy Parent Contract, that disclosure of such information is appropriate and in the best interests of the client;
- 5. If you are a perceived threat to yourself or others (suicidal or homicidal thoughts with a plan);
- 6. If I am subpoenaed and ordered by a judge to testify or release client information; and
- 7. When otherwise required by law.

<u>CONTACT POLICY/EMERGENCY SITUATIONS</u>: If an emergency situation arises for which you or your parent or guardian feels immediate attention is necessary and I am unable to return your call within 15 minutes, you agree to contact your family physician, call 911, or go to the nearest emergency room for help and emergency services. You can also call the crisis hotline, Behavioral Health Response at 314-469-6644 or Life Crisis Services at 314-647-4357 for assistance. I will be happy to follow-up any emergency services with standard counseling and support to you and/or your family.

<u>FEES, BILLING, AND PAYMENT</u>: While your insurance may cover a portion or all of the applicable fees, you (not your insurance) are ultimately responsible for full payment of the fees to Angie Hoffman, LPC. If you authorize Angie Hoffman, LPC to keep your credit card information on file, I will apply the charges for each session to your credit card automatically unless directed otherwise. You may revoke this authorization at any time by submitting a written request.

By signing below, you agree to pay for services at the time they are rendered, and you authorize that payment be made directly to Angie Hoffman, LPC. A fee of \$25 will be charged to the credit card on file for any returned checks. After 60 days, any unpaid balance will be charged 1.5% interest per month (18% APR). In the event that your account is overdue and turned over to our collection agency, you or your parent or guardian will be held responsible for any collection fee charged to my office to collect the debt.

<u>CANCELLATION POLICY</u>: If you need to cancel or reschedule an appointment, you are required to let Angie Hoffman, LPC know at least 48 hours in advance (by phone only) in order to avoid a late cancellation fee of a full session. If you are unable to inform Angie Hoffman, LPC at least 48 hours prior to the scheduled session or do not show up for your scheduled time, your credit card on file will be charged for the applicable full session fee. If you arrive more than ten (10) minutes after your scheduled appointment time, you will be asked to reschedule for a later date. After a total of three (3) late cancellations or "no call, no shows", you will be referred to services elsewhere.

<u>LEGAL ISSUES</u>: In the event that any legal action is necessary on behalf of the client, the client will be billed \$120 per hour (please note, this charge is not covered by insurance). This includes phone contact, client record reviews, and letter writing to the courts. Because client confidentiality is of the utmost importance, it is highly discouraged that I be asked to participate in any court cases in which clients are involved. It is important that clients feel that therapy is a safe place where they can express themselves freely. As a result, it is my policy that I do not make custody or visitation recommendations in regard to child clients. If client records are subpoenaed, it is my policy that the least amount of client information is provided to the court to protect both client confidentiality and the therapeutic relationship. As a Licensed Professional Counselor in the State of Missouri, I am mandated by law to report any suspicion or disclosure of child or elder abuse or neglect, intent to harm oneself, or intent to harm another.

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: The undersigned client or parent/guardian has received and read a copy of the Notice of Privacy Practices and Client Rights document.

<u>CONSENT TO TREATMENT</u>: The undersigned parent or guardian/client has read the above information and gives consent to treatment as a client by Angie Hoffman, LPC.

By signing below, I understand that I am signifying that I have read the information in this document and agree to abide by its terms during the professional relationship with Angie Hoffman, LPC. If I am not benefiting from treatment, Angie Hoffman, LPC will provide me with one or more referrals that may better serve my needs. I understand that I am free to end treatment with Angie Hoffman, LPC at any time. By signing below, (a) I consent to enter into treatment as a client of Angie Hoffman, LPC, or (b) I consent to treatment of my child as a client of Angie Hoffman, LPC. I further agree to pay the applicable fees listed on the Fee Schedule for any services provided by Angie Hoffman, LPC.

Client Name and Date of Birth if Under 18	Date	
Signature of Client if Over 18	Date	
Signature of Parent or Legal Guardian	Date	