Ella Deaver Counseling, LCSWA, LCASA, PLLC
Informed Consent For Services

Client Information	
Full Name:	
Date of Birth:	Age:
Address:	
Home Phone:	
Mobile Phone:	
Email Address:	
Who referred you to Ms. Deaver?:	

I am happy to have the opportunity to work with you on the issues bringing you to therapy. Our working relationship will be collaborative, where you will be safe and supported as you address the challenges you are currently facing. My hope is that you will find me to be a person to help you find the skills, solutions and perspectives to make positive changes in your life.

This agreement reviews my policies and information about my professional services and business policies. By reviewing and signing this document, before coming to your first appointment, you allow me to focus on your needs when you arrive for your first session. Please read carefully and sign and date the last page.

Therapy/Counseling: Psychotherapy can be very helpful, but it is also important to note that addressing difficult issues with a therapist can also bring about difficult feelings, such as sadness, anger, guilt, shame and anxiety. This is normal and natural and is part of the process; by addressing these issues, they can be addressed and the client can learn new skills to better understand and manage their emotions.

Initial Session: The first appointment is the time for you to let me know what brings you into the therapy office. We will discuss goals and your hopes for the therapeutic process.

Confidentiality: Confidentiality is the understanding that the information that you share with me is kept between us, including the fact that we work together. I do discuss cases with my

professional peers in case consultation at Potentials. They are also bound by ethical standards of client confidentiality. Generally speaking, I do not disclose information about a client unless authorized to do so by the client in writing. An exception to this is if I employ outside services to collect past due accounts; in signing this form you are authorizing this disclosure if necessary. There are several exceptions to confidentiality which are described in the attached Notice of Privacy Practices. The Health Insurance Portability and Accountability Act (HIPPA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. I am required by law to obtain your signature acknowledging that I have provided you with this information. By signing below you are certifying that you have been given a copy of this notice. You may revoke this agreement in writing and that will be binding unless she/he has taken an action in reliance of it. If there are obligations imposed on the clinician by your health insurer in order to process or substantiate claims or if you have not satisfied any financial obligations. Please know that all files are kept confidential. Your written consent is required for any release of information.

There are several exceptions to confidentiality that are mandated by law. These are: 1) if I believe that the client intends to harm her/himself, 2) if the client discloses child or elder abuse, neglect or exploitation to me or if I suspect child abuse or elder abuse, neglect or exploitation, and 3) if I am required to testify in a Court proceeding, the Judge may order me to produce records. A Subpoena signed by an attorney will not be enough for me to release therapy records.

Phone Messages: During regular office hours, phone calls are answered by office staff. In the evening, phone calls will go to voicemail. I make all efforts to return phone calls and messages within 24 hours. However, if you call and do not receive a return call within 24 hours during the work week, please call again. If you leave a message to cancel an appointment, I will leave it up to you to call back in order to reschedule.

Email: My preference is to use emails primarily for administrative and office procedures. Emails should only contain non-urgent matters. If you are experiencing an emergency, phone mail messages indicate how to reach me after hours. If it is an emergency, please call 911 or go to your nearest Emergency Department.

Social Media and Messaging: I do not accept requests on social media from my clients. This protects the boundaries of the therapeutic relationship and your confidentiality. I do have a professional Instagram page, Ella Deaver Counseling, which will include posts related to information about mental health and wellness. You may choose to visit this page without “following” as a way to protect your privacy while reading material or posts that might be helpful to you. As a general rule, I do not respond to text messages as a form of communication with my clients.

Ending Therapy: Ending therapy can occur at any time and can be initiated by either the client or the therapist. If you are unhappy with the therapy process, please share your concerns. This may assist in making changes to help your therapy sessions become more helpful to you. In

general, therapy ends when you have accomplished goals that were identified at the start of the therapeutic relationship. If you stop attending therapy, in general, I will not reach out to you out of respect for your decision. If you wish to resume therapy at another time, you are free to reach out to schedule sessions. The time has to be right for you to be engaged in therapy and the therapeutic process.

Rates: All payments are due at the beginning of each session.

- Initial Intake Interview- $165
- Subsequent Interviews- $150
- Additional time, per 15 minute increments- $50
- Telephone Consultation, per 15 minute increments- $50
- Services performed on behalf of the client- i.e. letter writing, completion of forms, per 15 minute increments- $50
- Therapy Session Fee- $150
- Court preparation/testimony- $2000 or $300 per hour, whichever is greater
- Affadavit of Fee- $500 or $300 per hour, whichever is greater

Cancellation and No-Shows: There is a charge for missed appointments and appointments cancelled with less than 24 hours notice. This charge is the sole responsibility of the client. Clients who do not show for two scheduled appointments will not be rescheduled. Clients are most successful in therapy when it is prioritized and there is investment in the process of therapy. Full fee is charged for intake and therapy appointments that are missed or cancelled less than 24 hours hours in advance. There will be no charge if you are ill or you experience a personal emergency.

Late Fees and Returned Checks: The returned check fee is $40. If you are delinquent in payment, you are responsible in full and will be charged in full any and all time spent on collecting for your account (i.e.- collections agency or attorney hired to collect your debt).

Testiifying: Participating in Court hearings is not a typical service. If I am subpoenaed, the rate is $300 per hour or $2000, whichever is greater, for all time total spent on responding to the subpoena, whether actual testimony is required. This could include reviewing clinical notes and speaking with attorneys, and any telephone calls, letters written or email correspondence on the client's behalf. If I am required to be in Court, I must cancel all clients for that work day, even when on "stand- by" notice. The party sending the subpoena is responsible for the entire bill. Preparing an Affidavit will cost $500 or $300 per hour, whichever is greater.

Informed Consent: Please sign below to indicate that you have read the preceding information in full and understand the information. If you would like, I am happy to read the forms and review them with you. Please ask for clarification of any information that is needed. Your signature indicates that you have read the document and agree to the terms of our professional relationship.

I have read and understand the policies and agree to the conditions. I agree to the statements herein and terms of payment, to include payment of all fees listed. If the client is a minor, I certify that I have the legal right to consent to treatment. I acknowledge receipt of HIPAA Notice of Privacy Practices.

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Signature Date