Client Informed Consent for Treatment by
Shelly Aldrich, LMFT (# MFC48048)
Bridges Counseling Center

Please read this document carefully, as we will discuss it during your first session. Please be sure to ask me any questions you might have regarding your treatment.

Client Name _____ Social Security # _____
(To be completed by the Parent/Guardian if client is younger than 18 years)

Confidentiality

All information between counselor and client is held strictly, confidential unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse/neglect are suspected

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

Regarding couples and family therapy, I maintain a "no secrets" policy, This means all information disclosed to me by participating members, may be disclosed to other participating family members. All persons involved in couples therapy or family therapy must provide written authorization to release confidential information regarding treatment, before it can be released to an outside party.

Minors and Confidentiality:

Communications between therapist and clients who are minors (under the age of 18) *are confidential*. However, I retain the right to disclose any "safety concerns" I have with parents, if it is believed disclosure will potentially enhance the minor's safety, and not increase risk. Parents and legal guardians are encouraged to actively participate in their child's treatment and may often attend parenting sessions with me. It is to be understood by both the minor and parent, that the general progression of treatment may be shared, but not specific details.

Parents please note that if your child is 12 or younger, you must wait for them in the waiting room during their scheduled session.

Fees:

The fee for service is: $125.00 per individual, family, or couple's therapy session. These fees are due and payable at the time of services. There is a $25 fee for all returned checks. Additional fees of $200.00 per hour are charged for time in court/ testimony.

I am currently not accepting insurance as a form of payment. However, I will be happy to provide you with monthly statements of services, which you can use to bill your insurance company directly. The statements will include insurance codes, diagnostic info., dates of services and payments made. Please let me know if you need this service.

Client Name _____ Social Security # _____

Canceled/Missed Appointments

A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, the client will be billed according to the scheduled fee ($125).

If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session.
Please initial here to indicate your agreement with the fees and cancellation policies_____

Therapist Availability/ Emergencies:

Telephone consultations between office visits are accepted. You are welcome to leave me a message and I will return your phone call as soon as possible. We should attempt to keep these calls to 5 minutes or less, and use the therapy sessions to deal with more extensive issues. Unless otherwise arranged, anything longer than 10 minutes will be billed at the hourly rate of $125 (rounded to the nearest quarter hour).

If you have a medical or psychiatric emergency, please call 911 or **A.C.C.E.S.S. at 888-886-5401.**

About the Therapy Process: Your treatment plan will be customized with you, based on intake information you provide and your treatment goals and needs. It is my intention to provide services that will help you in reaching your treatment goals. Part of your responsibility in therapy is to attend your scheduled apmts. consistently, complete homework and out-of-therapy assignments, and to actively participate in therapy sessions, as well as complying with guidelines listed above. Your efforts will enhance your progress in therapy and help you reach your goals. I believe that therapists and clients are partners in the therapeutic process. Please let me know if you have questions or concerns about the therapy, or if you are dissatisfied with treatment, so that these issues can be resolved.

Termination of Therapy: Therapy length will coorelate with your specific treatment plan, goals and progress being made. We will work collaboratively to plan for your completion of treatment and to help you begin to make the necessary adjustments, as you near the stage of treatment.

Consent for Treatment

I further authorize and request that Shelly Aldrich, LMFT, provide psychological or psychiatric examinations, treatments, and/or diagnostic procedures which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

_____	_____	_____
Clients name (print)	Clients Signature	Date
_____	_____	_____
2nd clients name or parents name (print)	Signature	Date