Center for Counseling, Growth & Discovery, LLC

The Sound Room at Polaris

8720 Orion Place, Suite 396

Columbus, OH 43240

Informed Consent

General Information: Counseling has been described as "*a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals*" (American Counseling Association.) The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process: You have taken a very positive step by deciding to seek therapy. Counseling is different than visiting a medical doctor in that it involves a partnership between you and your counselor. Counseling is not something done to you but rather it is something done with you. For counseling to be successful, you will need to work on your concerns in and outside of your sessions. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality: Any information that is conveyed in all therapy session is considered to be confidential. All written and verbal information and records about a client cannot be shared with another party without the written consent of the client, or the client's legal guardian. However, the following exceptions apply:

Abuse of Children and/or Vulnerable Adults: If a client states or suggest that she/he is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities, as a mandated reporter.

Duty to Warn and Protect: If I believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims and I believe you have the intent and ability to carry out the threat, then I may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) communicate to a law enforcement agency and if feasible, to the potential victim(s), or victim's parent or guardian (if minor) the following information: a) you identity, b) the nature of the threat, and c) the identity of the potential victim(s). I will inform you about this and obtain your written consent, if deemed appropriate under the circumstances.

Court Order: Mental health professionals are required to provide information in response to court orders and subpoenas.

Technology: Certain forms of technology can be intercepted by third-parties. These forms include cell phone usage and unencrypted email. These forms of communication may be used to help you with services and with coordination of services, which may take place outside of your scheduled session. As your mental health professional, I am not responsible for any interception by third parties during these exchanges. Confidentiality cannot be assured when using the internet, and these forms of communication. In the event that you contact me using these forms of communications, this constitutes implied reciprocal use of the same communication media.

Privacy Policies: Additional details regarding the information shared in session may be used in ways outlined in the privacy policies, given to you during your initial session.

I have reviewed, understand, and agree to the policies regarding confidentiality _____ (Initials)

Office Policies

Cancellation Policy

If you fail to cancel a scheduled appointment, I cannot use this time for another client. Consequently, you will be billed $75 for individual appts. and $125 for couples/family missed appts. The fee is charged for missed appointments or cancellations with less than 24-hour notice unless it is due to sudden illness or an emergency.

I have reviewed, understand, and agree to this policy regarding cancellation _____ (Initials)

Building Security Issues

Because of security issues which are mandated by other tenants within our building, access through the front door is limited to typical business hours. If you schedule an appointment outside of those hours, I will personally meet you at the door, and escort you to the waiting room. I will discuss this with you, during our first initial contact.

Office Hours

All clients are seen by appointment only. Counseling hours and days vary, depending on caseload, and the client's needs. Evening and Saturdays are also available. Administrative hours are Monday through Friday, from 9:00 am to 6:00 pm. Messages can be left any time on my voicemail, at 614-706-5590. All appointments are made using this same number.

Services and Fee Schedule

I understand that payment will be collected at the time of services. Payment may be made via cash, check, debit or credit card, FSA or HSA. In the rare case that payment is not collected, the full payment of services to date will be collected at the time of the next appointment. I understand that Center for Counseling, Growth & Discovery, LLC has no contractual obligation with my insurance company or me that would entitle or guarantee me reimbursement for expenses that I incur for services. I understand that I may request a receipt of payment that I may turn into my insurance company for possible reimbursement based upon my policy's out-of-network benefits; however, I am responsible for understanding my benefit plan and am liable for payment at the time of services.

Fees range based on the services provided. The initial session will be 60-90 minutes and will include a full assessment and intake. Fees will be $175 for individuals, and $250 for couples, for the initial appointment. A $75 **non-refundable** fee is required to schedule an initial session. This deposit will be applied to your session fee. Subsequent sessions for psychotherapy are $100 for individuals and $200 for couples. Normal session lengths are 50 minutes, and include time for the counselor's documentation, phone calls, notes, and planning for the next session. A credit card is required to be on file with our office.

Card number _____ Exp: _____ CVV: _____ Zip:_____

Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request. These services will be billed at a prorated rate of the regular hourly rate ($100). If you become involved in legal proceedings that require my participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if called to testify by another party. You will be charged $200 per hour for these activities. Please note that insurance companies will not reimburse you for these services. If you request documents to be prepared for other entities, you will also be charged a prorated fee of $100 per hour for the completion of these documents.

All fees are subject to change without prior notice.

Privacy Rights

I hereby acknowledge that I have been given an opportunity to access Center for Counseling, Growth & Discovery, LLC. Notice of Privacy Practices online at http://www.counselgrowdiscover.com/client-portal/ or receive a copy in person. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lisa Bushman at 614-706-5590.

X _____ X_____

Print Name of Client Print Name of Client's Representative

X _____ _____

Signature of Client / Client's Representative Relationship / Authority to Act on Behalf