Informed Consent for Services

Client Name: ______________________________________ Today's Date: ___________
Address: ____ DOB: __________________

I hereby give my consent to enter into counseling services with Tammy Blodgett, LPC and all associates. I understand by engaging in counseling with Tammy Blodgett, LPC, I agree to the following:

Counselor
I have been made aware of my counselor's qualifications and have chosen to engage in counseling with her. I am aware that my counselor holds a LPC license with the Texas State Board of Examiners of Professional Counselors (License #72072).

Nature of Counseling
I understand I must be honest and willing to share personal information about myself if counseling is to be effective. I understand that counseling may at times be difficult and/or unpleasant, depending on the nature of the issues I address. I further understand that for counseling to be effective, I must be an active participant.

I understand that my relationship with my counselor is strictly professional and that my counselor will not acknowledge me in public unless initiated by me (and my counselor will not engage in an extended conversation with me in a public place). Further, I understand my counselor will not attend any social events with me or engage in any activities outside of counseling at the counseling office.

Assessment & Evaluation
I understand my first session will be a diagnostic evaluation, in which my counselor will gather personal information for the purpose of determining issues that need to be addressed and recommendations for how to address such issues. I understand my evaluation may result in a diagnosis, if required by my insurance company or other third party payer. I understand my counselor may, at times, utilize testing instruments (i.e. Beck Depression Inventory, SASSI, etc.) in order to best determine my counseling needs.

Course of Counseling & Treatment Planning
I understand the number, frequency, and duration of my counseling sessions will be determined upon my specific needs. I understand that I will collaborate with my counselor to develop a treatment plan and agree to work toward rny treatment goals.

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Family Involvement
I understand I may request family involvement in my counseling and agree to discuss this with my counselor prior to scheduling any such session(s).

Confidentiality & Records
I have been made aware of the confidentiality/privacy policies of Tammy Blodgett, LPC and all associates. I understand my counselor may not disclose information about my counseling without my express written consent, except in those situations identified in the Confidentiality/Privacy Notice.

Possible exceptions to confidentiality include but are not limited to the following situations: abuse or neglect of minors, elders, or disabled persons ; abuse of patients in mental health facilities (§681.33 TAC, Ch.681); criminal prosecutions (§611.004 Texas Health & Safety Code, Ch. 611); child custody cases (§ 611.006 Texas Health & Safety Code, Ch. 611); situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn or disclose (§ 611.004 Texas Health & Safety Code, Ch. 611); fee disputes between the therapist and the client (§611.006 Texas Health & Safety Code, Ch. 611); or the filing of a complaint with the licensing board (§611.006 Texas Health & Safety Code, Ch. 611).

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist at any point during your treatment.

I understand my counselor will maintain a record of my counseling, which will be kept for 7 years after termination of counseling, if I am an adult. My record will be kept for 7 years past my 18th birthday, if I am a minor.

Termination of Services
I understand I may choose to terminate counseling services at any time and I am aware that my counselor may recommend termination of counseling services and provide referrals if she feels it's in the best interest of the client.

Payment of Services/Insurance

Payment is expected at the time services are rendered and you will be provided a receipt for services.

I accept most major credit cards, and cash. Please note many insurance companies do reimburse for out-of-network mental health services, you will need to verify what your particular plan covers.

Within contract guidelines, the undersigned therapist will look to you for full payment of your account, and you will be responsible for payments of all charges including NSF Bank charges.

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I acknowledge and agree to pay Core Life Counseling for services provided by Tammy Blodgett, LPC.

Initial Diagnostic Evaluation: $150.00
Individual Session: $125.00
Family/Couples Session: $150.00
EMDR Diagnostic Evaluation: $200.00
EMDR Session: $150.00

In the event disclosure of your records or testimony is required by law, ***payment will be expected from you, regardless of whose attorney subpoenas my involvement.*** Client records will not be released without written consent, unless court- ordered to do so. Please note: a subpoena does not constitute a court order.

CRISIS SITUATIONS

In the event of a crisis, every effort will be made to return your call & schedule if necessary. However, please understand that your therapist may be in sessions & unable to return your call until later in the business day. Should you need immediate assistance or experience a crisis after hours or on the weekend, please call 911 or contact the Contact Crisis Line at 1-972-233-2233 or the National Suicide and Prevention Hotline at l-800-273-TALK(8255) or go to your local Emergency Department for evaluation.

Duty to Warn/Duty to Protect

In the event my therapist believes I am at risk of harming myself or someone else, I give my permission for my therapist to contact anyone who is in a position to prevent said harm, including the person who is in danger, if applicable. Further, I give my permission for the following persons Name: __________________, Phone: ______________, to be contacted in addition to any law enforcement or medical personnel contacted:

Cancellations

I agree to attend all of my scheduled sessions and to call at least 24 hours ahead of time if I will not be able to attend my session for any reason. I understand I will be required to keep a credit card on file and it may be charged the full session fee, based on my appointment classification (individual, couple or family) if I cancel less than 24 hours before my scheduled appointment or do not attend my scheduled session.

PLEASE NOTE: Insurance does NOT pay for late cancellations or no-shows.

I understand my counselor will make every effort to work with my scheduling needs, as possible within my counselor's schedule & office availability.

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By signing the Consent for Services form, I the undersigned client, acknowledge that I have both read and understand all the terms, conditions, & information contained herein. I have been provided sufficient opportunity to ask questions and seek clarification of anything contained in this agreement that is unclear to me.

______________________________________ ____________________

Client Signature Date

______________________________________ ____________________

Client Legal Guardian Signature Date