CARMICHAEL COUNSELING

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Welcome to Carmichael Counseling, LLC. I realize that starting therapy services is a major decision and you may have many questions. This document contains important information about my professional services, business policies and your confiditality. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PROFESSIONAL SERVICES AND POLICIES

CODE OF ETHICS

Carmichael Counseling will, at all times, work to carry out its mission with the highest standards of business, marketing, employment practices, service delivery, cultural awareness and professional responsibilities in order to protect the people served, community, and our employees. Therapy will be delivered using methods shown to be effective by research-based evaluations and/or field recognition. I am licensed by the State of Nebraska and follow the American Counseling Association (ACA) Code of Ethics.

THE THERAPY PROCESS

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

CLIENT INPUT

Developing an informed trust relationship and maintaining that relationship with you and your family is crucial for successful treatment outcomes. Therefore, I believe in having all treatment planning and progress discussions with you present, unless it is therapeutically unwise. Your input will be obtained during the assessment process by completing a detailed interview and questionnaire focusing on your background. Your input regarding goal achievement will be obtained through direct involvement in the development of your treatment goals and regular evaluation of your progress.

HOLISTIC COUNSELING

Therapy at Carmichael Counseling is conducted holistically. This involves addressing the following four general areas of life: **spiritual**, **psychological**, **social** (school, parents, extended family, etc.), and **physical** (both biological and environmental/financial). I recognize that our struggles often overlap in several of these areas, and I may ask your permission to bring them into the therapeutic relationship as necessary. The spiritual area, as with all the other areas, is handled on an individual basis. I understand that people hold differing beliefs regarding spiritual issues, and I seek to be sensitive and appropriate when this or any other issue is discussed.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in the Notice of Privacy Practices and Client Rights and Responsibilities. You are expected to review those documents before signing

this consent form. A copy can be found on my website, in the lobby of this office, or available by request at any time. If you have any questions about confidentiality and protection of your health information, please discuss those with me.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes the following information: your reasons for seeking therapy, a description of the ways in which your problem impacts your life, diagnosis, the goals that we set for treatment, progress toward those goals, medical and social history, treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that I believe disclosure would physically endanger you, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I may recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents.

MINORS & PARENTS

Clients under 19 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to progress, particularly with teenagers, it is sometimes my recommendation that parents do not request access to their child's records or details of their disclosures. In such cases, I may provide parents with only general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. If I feel that the child is in danger or is a danger to someone else, I will notify the parents, and possibly the authorities, regardless of the child's consent.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. When your appointment is scheduled, I dedicate that time for your individual session. You are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. I realize emergencies come up and you may not be able to keep your appointment. If you are unable to keep your appointment, please give 24 hours notice. Missed appointments or appointments cancelled less than 24 hours in advance may prevent me from serving someone else in need. Because of this, You will be charged a $100.00 fee for missed appointments or appointments not cancelled at least 24 hours in advance of the scheduled session. (Unless we both agree that you were unable to attend due to circumstances beyond your control.) It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the fee as described above. If it is possible, I will try to find another time to reschedule the appointment.

PROFESSIONAL FEES

The standard fee for the initial intake is $135.00 and each subsequent session is $100.00. A Drug and Alcohol Evaluation will be billed at a rate of $150. You are responsible for paying at the time of your session unless prior arrangements have been made. You may choose private (out-of-pocket) payment or use your insurance. Accepted forms of payment include cash or debit/credit card. I can also accept Eligible Health Savings Account (HSA) or Flexible Spending Account (FSA) cards. Personal checks are not accepted until a consistent professional relationship has been established. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. Any account past due by 90 days may also be subject to interest charges of 1.50% per month. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you, not your insurance company, are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator.

In order for me to bill your insurance on your behalf, you must agree to authorize your insurance benefits to be paid directly to Carmichael Counseling and authorize Carmichael Counseling to release any information necessary to process Insurance or Employee Assistance Claims.

NON-COVERED SERVICES

In order to offer you consistent quality care and to coordinate this care with other providers or organizations, I may need to charge for services that are not typically covered or reimbursed by your insurance company. A list of these services is provided below. When I provide these services, I will bill you directly. If you have any questions regarding this policy, please ask. The following are a list of some of the services not covered by insurance companies. These services are billed at the standard hourly rate:

- Court ordered and legal related services (including reports, testimony, travel, etc.)
- Preparing reports or letters for other providers or organizations
- Completing documents (for disability claims, insurance reviews, workers' compensation, etc.)
- Consultations by telephone or e-mail
- Duplication of your medical records
- Evaluating, testing or treatment services not covered by your insurance

If at any time you have questions regarding insurance, fees, balances or payments, please feel free to ask me.

CONTACTING ME

My office number is 402-750-1222. You can call or text me at this number for any reason. However, I am not always immediately available if I am with clients or you contact me outside of office hours. If you are unable to reach me, you may leave a message on my confidential voice mail, send me a text message, or e-mail me at kirk@carmichaelcounseling.org. I will get back with you as soon as possible. If, for any number of unseen reasons, you are unable to reach me and you feel you are in an emergency situation or you feel unable to keep yourself safe, please call 911. If I am unavialbe or do not immediately respond, it is your responsibility to contact 911 for any emergency.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

SAFETY AND SECURITY

Carmichael Counseling is committed to maintaining a safe environment for all individuals. Because safety is my highest priority, the following policies will be followed.

- Any aggressive behavior will not be tolerated. This includes, but is not limited to, shoving, pushing, hitting, using obscenities toward people, threatening, yelling, using obscene gestures, self-harm, or the intentional destruction of property.
- No possession of weapons, hazardous materials, or illicit substances will be allowed on the property to help maintain a safe environment.
- Carmichael Counseling reserves the right to ask disruptive individuals to leave the office and possibly permanently expel anyone if a violation is serious in nature, even if it is the first offense. Law enforcement may be called to intervene for any offense, if it is warranted.
- Carmichael Counseling has visual monitoring cameras within the waiting room and therapy offices. Cameras do not record audio and are only used to monitor activity and ensure a safe environment. The images of clients from such cameras will be considered part of protected health information. Use and disclosure of video images will be restricted to the minimum necessary to accomplish safety and be HIPAA-compliant.

AUTHORIZATION AND INFORMED CONSENT

Client Full Name: ____ Date of Birth:____/_____/_____

I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health and substance abuse assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

I have been given the opportunity to read the "Notice of Privacy Practices" and "Client Rights and Responsibilities" and have had an opportunity to ask questions about them. I know and fully understand its contents, execute it freely, and have been offered a copy for my/our own records.

I authorize my insurance benefits to be paid directly to Carmichael Counseling and understand that I am financially responsible for non-covered services. I also authorize Carmichael Counseling to release any information necessary to process insurance or employee assistance claims. (A photocopy of this authorization will be considered valid.)

If signing as guardian or for a minor I, __________________________________, testify that I am the legal guardian of this client, and I give consent for Carmichael Counseling to provide mental health or substance abuse services to this client and all other family members of my household who may be asked to participate in therapy.
Attach proof of guardianship (if applicable).

____
Client Signature

Date Signed: ________________________________

____
Parent, Guardian, Authorized Representative Signature

____
Witness Signature

____
Relationship to Client