Sharon M Gaffney Counseling

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1300 Capitol Drive, Suite 103
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CONSENT FOR TREATMENT

Welcome to Sharon M Gaffney Counseling LLC. What follows explains the rights and responsibilities within the therapeutic relationship. It is important to be aware of the following as it helps to create safety and support to become empowered for change. This constitutes your informed consent regarding treatment as well as my administrative polices.

Clients Rights and Confidentiality
Your treatment and care will be kept confidential. By signing you acknowledge that you have received a copy of and have read Sharon M Gaffney Counseling, LLC's "Client Therapist Agreement" and "HIPAA Notice of Privacy Practices", you have been made aware of how my Personal Health Information may be used and disclosed. Information about you will only be released with your written consent, except in situations that are required by law or in cases in which you have been referred or ordered by the Court. By law, I must release information in situations of (1) abuse or neglect of children; (2) abuse or neglect of the elderly; or (3) cases of probable suicide or homicide. In these cases, I may need to take steps to protect people from harm or to warn them such as (1) contacting a family member; (2) contacting a public agency; or (3) arranging for hospitalization.

There is no recording of any kind permitted in the offices of Sharon M Gaffney Counseling LLC unless written consent is given.

Special Notes Regarding Minors
Confidentiality and Minors: A parent who consents on a minor's behalf has the right to know the content of the child's treatment plan. The state of affairs changes when the minor reaches the age of majority (18). Until that time, the law will normally give the parent access to the child's treatment. An important aspect of treatment is to foster the child's autonomy/independence. I request that the session will be confidential in order to foster the client/therapist relationship, develop trust, and to expedite the therapeutic process. Such decisions to breach confidentiality are listed above; however, when deemed in the best interest of the client, the client and therapist will work together to discuss with the parent any pertinent information that the parent should know. A person who is 14 years or older must agree with his/her/their parent to receiving outpatient mental health services.

Benefits and Risks
Counseling can offer many benefits, including new ways of understanding yourself and your relationships, finding a clearer path to identifying and achieving your goals, unblocking placed you feel stuck, and improving your relationships and quality of life. Therapy may lead to decisions about changing jobs, homes, schools, partners, or other aspects of your life. You determine the nature and amount of change you wish to make. However, any improvements cannot be guaranteed for any condition due to the many variables that affect therapy sessions.

Counseling can also involve risk. In counseling, major life decisions are sometimes made. The decisions are a legitimate outcome of the counseling experience as a result of individuals calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the

emotional experiences may be too intensive to deal with at times. I am available to discuss any of your assumptions or possible negative side effects encountered in your therapeutic work.

Records
Licensed mental health care providers are required to maintain records of each time we meet or talk on the phone. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. Also, for insurance reimbursement, I will need to assign you a diagnosis. If you have any questions about this, please talk to me. If your records are subpoenaed as part of court proceedings, I many comply in providing records by following state statutes. The State of Wisconsin requires that records be retained for seven years, after which they are destroyed.
A fee will be charged for a records request.

Fees/Insurance/Appointments
The Following fees reflect charges for services:

Initial Assessment (Intake – 60-90 minutes): $200
Individual, Couples, and Family Therapy sessions (45-50 minutes): $150
Group Therapy Sessions: (Varied)

Sharon M Gaffney Counseling LLC accepts insurance reimbursements as payment for service. I will verify benefits to the best of my ability before your initial appointment. The client is responsible for obtaining any necessary preauthorization and for notifying me of any changes to your insurance. The client is responsible for all charges that are not covered by insurance. Any unpaid balances must be paid within 30 days of the invoice date. I reserve the right to charge interest on any unpaid balance each month. I reserve the right to refuse services for any clients with unsettled accounts after 60 days.

Payment options include cash, checks and credit cards (Visa, MasterCard, Discover, American Express, Debit Cards processed as Credit and HSA/FSA/MSA Cards). If you would like to keep a credit card on file, please complete the credit card authorization form. Please write checks out to Sharon M Gaffney Counseling.

Other payment options, such as sliding fee scale arrangements based upon your income, should be discussed before your first appointment. Please be prepared to make your payment at the beginning of each session.

I, the client, understand my assessed fee to be $_____per clinical hour or per session.
COLLECTIONS: Past due accounts may be turned over to my collection agency/attorney. All fees incurred by this action will be the responsibility of the client.

Cancellation Policy
My policy requires 24 hours' notice for cancellation of any appointment. You may call and leave a message on voicemail, which will time stamp the call. If the cancellation of an appointment is not received on time, a $75.00 fee will be charged. An invoice for payment will be mailed to you, payment of which is due before your next scheduled appointment. Failure to show up for a scheduled appointment will result in the same charge and process for billing and may be cause for termination of services and/or a referral to continue your treatment.

Referrals
I may deem it appropriate to make a referral to another practitioner for specific services. Referrals will be made to known professionals in the field and related fields. Knowledge as to their competence comes in part from reports from other clients, and thus, I cannot take personal responsibility for their competence.

Emergencies
Phone messages will be returned as soon as possible. There will be no charge for, brief, return phone calls and/or emails. Sharon M Gaffney Counseling, LLC is not available in an emergency. If you need immediate help, please dial 911, or go to your nearest emergency room or local hospital for evaluation. Please see the Emergency Contact Information Sheet for more information.

Electronic Communication
I may communicate with you via text and/or email for scheduling purposes. Text and email messages are not guaranteed to be confidential; cell phone and internet providers retain logs of all messages and content may be accessible to unknown persons. If you choose to text or email me, you accept this possible lack of confidentiality. I may also document and retain text and email messages as part of your record.

I will not accept any client invitations to connect on any social media platform. This is to protect the integrity of the therapeutic relationship as well as our mutual confidentiality and privacy.

Consultation and Training
Sharon M Gaffney Counseling LLC is a self-employed entity. The therapists at On Purpose Psyche LLC and Creating Balance LLC are also individually self-employed. However, we consult with one another regarding clinical matters when multiple members of a family are being seen by multiple therapists and/or to ensure that we are providing the best possible services. We take every measure possible to preserve your right to confidentiality when doing so.

Sharon M Gaffney Counseling LLC as well as On Purpose Psyche LLC is a training center for Master's level counseling interns. All counselors are under the supervision of a licensed mental health professional. Permission to discuss material from therapy with professional supervisors, including group sessions, is only for the purposes of aiding in professional development. This is a standard practice in the counseling/therapeutic community. You have the right to not give the authorization to discuss material from your therapy sessions.

Termination
It is always best to have a closing session when finishing therapy. If for some reason you chose to forgo this session, and do not inform your therapist that you are through with therapy, I will reach out to you two times, over the course of 30 days, to try to contact you about rescheduling/terminating. If I do not hear from you, I will call you at or after the end of the 30 days, to inform you that Sharon M Gaffney Counseling LLC will be closing your file, and you will no longer be considered a client. You are always welcome to reach back out in the future after this phone call, should you wish to begin therapy again.

Consent for Treatment
I request and authorize Sharon M Gaffney Counseling, LLC to provide and perform counseling, therapy, coaching, consulting and other psychological-based interventions which are considered advisable for my health and well-being. I understand that Sharon M Gaffney will request my participation in developing my plan for treatment including informing me of the benefits and

expected outcomes for treatment, the type of treatment, and alternative options and problems that may arise if I don't receive treatment. I further understand that Sharon M Gaffney Counseling, LLC cannot guarantee the outcome of the treatment provided.

I have received a copy of and have been informed of the policy on confidentiality and client's rights. I have read and understand the above information. I understand that this consent for treatment is good for no longer than 15 months and may be revoked by me at any time by written notice to my treating provider. I further understand that I am responsible for any costs incurred before the revocation of the consent for treatment and that any information released by my consent before revocation of consent for treatment cannot be retrieved. I hereby consent to treatment.

_____

Client Name (Printed)

_____

Client Signature (ages 14 and up) Date

_____

Parent/Guardian Signature (if a minor under age 18) Date

_____

Therapist Signature Date