Lisa Rector, LCSW

Counseling and Psychotherapy

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CLIENT CONSENT FORM

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

AVAILABLE SERVICES: I offer a wide array of counseling services, including individual, family, couples, and group services. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is my intent to convey the policies and procedures used in our practice; I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, or sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some possible benefits are improved relationships, reduced feelings of emotional distress, and specific problem solving. Although I cannot guarantee these benefits, it is my desire, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: I provide counseling designed to address many of the issues my clients are dealing with. Your first visit will be an assessment session in which you and I will determine your concerns, and if both agree that I can meet your therapeutic needs, develop a plan of treatment. The goal of treatment is to provide an effective therapeutic experience. If at any time you feel that you and I are not a good fit, please discuss this matter with me to determine if transferring to a more suitable Therapist.

Wellness is more than the absence of disease; it is a state of optimal physical, mental and spiritual health. It goes beyond the curing of illness. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide clients an integrated solution to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 45 to 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate. If you must cancel or reschedule your appointment, I ask that you call my office at least 24 hours in advance, whenever possible. This will free your appointment time for another client.

FEE SCHEDULE:

● Diagnostic & Evaluation Session (1st visit, 60 minutes)	$185.00
● Regular Office Visits (50 minutes)	$175.00
● Late cancel (less than 24 hrs) or no-show fee	$60.00
● Outside Office Work (at client request) (prorated)	$175.00/hour

PAYMENT/INSURANCE FILING: Payment of fees, and required co-pays, is expected at the time of each appointment. I request payment be made before your session begins. If you are not using an insurance plan or wish to file your own claim, I expect full payment at the time of service.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. It is not always possible to return your call immediately. If you are experiencing an emergency, call the UNI hotline at (801) 587-3000, or call 911, or have someone take you to the nearest emergency room.

CONFIDENTIALITY: I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards, to keep counseling records. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you. Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. The exceptions mandated by law include but are not limited to the following: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; prenatal exposure to controlled substances; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or protect, fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to my attention for discussion. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you, and the insurance carrier responsible for providing your mental health care services and payment for those services; you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel:

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Contact Name/ Relationship Phone Number

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that 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 assessment, treatment and services for me (or my child if said child is the client). I understand that I may stop such treatment or services at any time.

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Client Name

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Client/Guardian Signature Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes, and the payment of medical benefits to the provider of services.

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Client/Guardian Signature Date