Confidentiality, Consent for Treatment, Fee's

Each treatment that I receive has risks and benefits associated with it. The risks and benefits are described below and have been explained to me. My signature indicates that I wish to receive this treatment and that I have had these risks and benefits explained to me.

INFORMED CONSENT FOR TREATMENT

1. The approach to counseling and psychotherapy will reflect the various evidenced based therapeutic modalities and is a collaborative effort between the therapist and client. By entering into this therapeutic relationship, I am stating that I am prepared to attend scheduled appointments and partner in the counseling process. I understand that the counseling time is valuable, and that my counselor is committed to working with me/my child.

2. I have the right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy on behalf of a minor client.

3. My counselor uses a variety of communication to stay in contact including phone, text messaging, and email, if preferred. However, Kate Jiggins, LPCC-S, LICDC-CS cannot be reached 24 hours a day and/or for emergencies. Furthermore, emergencies are never addressed via text messaging and/or email. If I am experiencing an emergency, I will contact Netcare in 614-276-CARE (2273), dial 911 or go to the nearest emergency room.

4. My appointment time has been blocked off for me. I will make every effort to keep my scheduled appointment. If I am unable to keep my appointment, I know that it is expected to give 24-hour notice. I understand that I will be charged a $75.00 fee for late cancel or no-show appointments. Direct messages for Kate Jiggins, LPCC-S, LICDC-CS can be left by calling or texting 740-215-4372 or via email katej@att.net

5. By signing this document I am stating that I understand that treatment goals may not be successfully achieved should I decide to discontinue treatment against the advice of my own or my child's therapist.

6. The right to be informed in advance of the reason(s) for discontinuance for service provision, and to be involved in planning for the consequences of that event, the right to receive and explanation of the reasons for denial of service, and the right to know the cost of services.

7. I understand that I have the responsibility to provide accurate and complete information in-order for treatment to be appropriate and effective.

8. Kate Jiggins, LPCC-S, LICDC-CS uses several therapeutic techniques in counseling including but not limited to EMDR (Eye Movement Desensitization and Reprocessing). This technique can be helpful in some situations with some clients. If determined by Kate Jiggins that the use of this technique may be useful to me or my child, information will be offered and these services and provide opportunities for me to ask questions and obtain additional information to inform me of their potential risks and benefits.

Since therapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health services have also been shown to have benefits for people. Treatment may often lead to better relationships, solutions to specific problems, and significant reductions in the feelings of distress. Although people generally do well in counseling, I understand that we are all unique and there are no guarantees to the outcomes I may experience.

CONFIDENTIALITY – review Notice of Privacy

The code of ethics of the American Psychological Association and other counseling boards ensure that the conversations you will be having with your counselor will be held in strict confidence. There are, however, certain exceptions to this important rule. The Notice of Privacy Practices explains this information in detail.

1. The child abuse reporting laws of Ohio require my counselor to report to Children's Services any suspected physical, sexual, or emotional abuse, neglect or abandonment of any child that is currently under the age of 18 years.

2. My counselor is mandated by law to warn and protect any intended victim if there is reason to suspect bodily harm on myself or someone else.

My counselor reserves the right to inform possible affected parties and/or make appropriate referrals, if necessary, including contacting the police.

3. Ohio law requires professionals to report elder abuse, neglect, exploitation, or the suspicion of abuse to the Department of Human Services.

4. If I am involved in a court proceeding and a request is made for information concerning my treatment, my counselor cannot provide such information without my (or my legal representative's) written authorization, or a court order. If I am involved in, or contemplating litigation, I should consult with my attorney to determine whether a court would be likely to order my therapist to disclose information.

5. If a government agency is requesting the information, my counselor may be required to provide it.

6. If I file a complaint or lawsuit against my counselor, Katie Wine-Appleton, may disclose relevant information about me in order to defend herself.

7. If I file a worker's compensation claim, Katie Wine-Appleton may, upon appropriate request, have to provide a copy of my records or a report of my treatment.

Consulting with Other Therapists and My Attorney

By signing below, I agree that Katie Wine-Appleton may consult with other therapists and other health care providers about my care. In addition, from time to time, Katie Wine-Appleton may feel the need to discuss legal issues involving my case with her consulting attorney.

INSURANCE AND FEE'S

Please review this agreement before signing. By signing this form, I agree to abide by the fee agreement. I also understand that I am financially responsible for charges not covered by my insurance.'

I understand that I am responsible for obtaining necessary insurance authorization / referrals and for confirming coverage and agree to notify the therapist of any changes in insurance coverage.

By signing this form, I acknowledge that if although insurance will be billed directly, that I am responsible for the balance of my account for services rendered, regardless of any payments or promise for payment by my insurance or other third party.

Prompt payment is expected from you of any insurance payments made directly to you for counseling services.

Payment is expected on the day of service. I understand that if I choose to not submit an insurance claim, I will be expected to pay full cash fee. The full cash fee for an initial intake appointment is $125.00; counseling sessions thereafter are $110.00

I understand that I am responsible for filing complaints or suits against my insurance company if they deny or delay payment on an eligible visit.

By signing below, I understand that in the event that myself or my insurance company do not pay for services that Kate Jiggins, LPCC-S, LICDC-CS may send my information to a collections agency to collect any balances due. If this occurs, Kate Jiggins will only release enough information about me to collect the debt. A collection fee of 25% will be added to the reported debt amount.

By signing below, I consent to the disclosure of necessary information to my insurance company, which is required for billing (diagnosis, treatment plans, dates of service, and, if required, treatment progress). I also give consent to bill my insurance company for services rendered.

CANCELLATION POLICY:

I understand that insurance does not cover "missed appointment" fees.

I understand I will be charged a minimum amount of $75.00 for late cancellations (appointments cancelled without 24-hour notice) and a fee of $75.00 for a no-show appointment. Clients who do not give a 24-hour notice for cancellations or who do not keep scheduled appointments may be terminated.

I have had the opportunity to discuss this consent with my therapist.

My signature certifies that I have either received or reviewed a copy of the **"Notice of Privacy Practices"** or waived that right. I understand that I can obtain a copy at any time from my counselor and/or the website katejcounseling.com

I do hereby give full voluntary consent/ authorization to the treatment for myself and or my child/family under the conditions set forth.

_____ Date: _____

Client Signature

_____ Date: _____

Parent/Legal Guardian Signature - minor

_____ Date: _____

Kate C. Jiggins, LPCC-S, LICDC-CS