Informed Consent Agreement

Welcome to Ascensions Counseling Center. This document contains important information about our professional services and business policies. We ask that you read this carefully and sign it as an acknowledgement of your agreement to abide by these policies for the protection of your privacy and health information.

COUNSELING SERVICES

This is a professional counseling practice that offers counseling services to individuals who may elect to integrate Christian principles into the process of resolving personal issues. While all of our therapists come from a God-centered understanding of people, each has a unique background and training. There are also a number of different approaches used by our counselors, which can be utilized for the problems you hope to address. We encourage you to discuss with your counselor his or her background and training before you proceed with counseling in order to ensure that you are comfortable and confident with him or her.

Participation in therapy is key and may result in a number of benefits to you (and/or your child), including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Counseling/therapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior.

During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. Initially we will focus on evaluating your needs. By the end of the evaluation, we will be able to offer you some impressions of what our work will include and a plan for treatment. If you have questions about the procedures employed by your counselor/therapist, please discuss with them whenever they arise.

CONFIDENTIALITY

You have privacy rights under a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think your rights are being denied or your health information isn't being protected.

Our facility cares about your privacy. The information we collect about you is private. Only people who have both the need and the legal right may see your information. For example, parents or legal guardians of non-emancipated minor clients have the right to access the client's records. Unless you give us permission in writing, we will only disclose your information for purposes of treatment, payment, and clinic operation, when we are required by law to do so, or for the other reasons listed below:

- Relating to an agreement with a qualified service organization/business associate;
- For research, audit, or evaluations, or consultations or supervision;
- To report a crime committed on our premises or against our personnel;
- For medical personnel in a medical emergency;
- For appropriate authorities to report suspected child or elderly abuse or neglect;
- As allowed by a court order and/or government agency.
- If you file a complaint or lawsuit against Ascensions Counseling, we may be required to disclose relevant information about you for our defense.
- If Ascensions Counseling is being compensated for providing treatment to you as a result of your having filed a worker's compensation claim upon appropriate request, we will provide information necessary for utilization review purposes.
- If you communicate a threat of physical violence against a reasonable identifiable third person and we judge you to have the apparent intent and ability to carry out that threat in the foreseeable future, we may have to disclose information in order to take protective action. These actions may include notifying the potential victim, contacting the Department of Social Services, the police, and/or seeking hospitalization for you.

Again, before our facility can use or disclose any information about your health in a way that is not described above, we must first obtain your specific written consent allowing us to make the disclosure. You may cancel any such request in writing.

YOUR RIGHTS

You have the right to decide whether to give your permission before your information can be used or shared for certain purposes.
Your health information cannot be used or shared (outside of the exceptions listed above) unless you give your permission by signing a Release of Confidential Information form. This form must specify who will get your information and the purpose for which it will be used. You may cancel any such written consent in writing.

You have the right to ask to see and get a copy of your health records.
You also have the right to inspect and copy your own health information maintained by this facility, except when the information contains psychotherapy notes separate for your record or information compiled for use in a civil, criminal or administrative proceeding, or in other limited circumstances.

You have the right to have corrections added to your health information.
You can ask to change any wrong information in your file or add information to your file if it is incomplete. Even if this facility believes that the information is correct, you have the right to have your disagreement noted in your file.

You have the right to ask for confidential communication. You can make reasonable requests to be contacted at different places or in a different way. For example, you can ask that calls from the clinic be made to your cell phone instead of your home phone.
You have the right to receive a report on when and why your health information was shared.

Under the law, your health information may be used and shared for particular reasons (as described above). You can ask for and get a list of who your health information has been shared with for these reasons.

CLINIC DUTIES

This facility is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. This facility is required by law to abide by the terms of this notice. This facility has the right to change the terms of this notice and to revise this notice for all protected health information it maintains. A revised notice will be provided to you upon request through the clinic staff where you are being serviced.

COMPLAINTS AND REPORTING VIOLATIONS

You may complain to this facility and the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated under HIPAA. You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

You may contact the Detroit Michigan Office of Recipient Rights at: 1-888-339-5595. Information about how to file a complaint with the U.S. Government can be found at the website www.hhs.gov/ocr.hipaa/.

APPOINTMENTS

Once counseling is initiated, a 50-minute session is scheduled. A 24 hour notice is requested when canceling an appointment. You will be expected to pay the therapist's full fee unless you provide 24 hours advance notice of cancellation (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.

PAYMENT

Payment of cash, check, or credit/debit card is due at the time of each appointment, unless other arrangements have been made. A receipt will be given that you can submit to third party payment sources.

Your counselor/therapist may also charge you for other professional services you may need, and will let you know verbally or in writing what the fee will be before providing the service. No fee for non-therapy services will ever be charged without your knowledge and approval ahead of time. Other services include report writing, telephone conversations lasting longer than 10

minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request.

If you become involved in legal proceedings that require participation by your counselor/therapist, you will be expected to pay for all of the therapist's professional time, including preparation and transportation costs, even if the therapist is called to testify by another party.

EMERGENCY ACCESSIBILITY

If you need to talk to your counselor between sessions, leave a message on voicemail if they are not available to accept your phone call. Messages are checked daily. Telephone calls that last longer than 10 minutes will be billed at the agreed-upon hourly rate. Clients should go to a local hospital, or one covered by their insurance company, for emergency mental health or medical services.

MINORS AND PARENTS

Patients under 18 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. They should also be aware that patients over 14 can consent to (and control access to information about) their own treatment, although that treatment cannot extend beyond 12 sessions or 4 months. While privacy in counseling/therapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually our policy to request an agreement from any patient between 14 and 18 and his/her parents allowing the therapist to share general information with parents about the progress of treatment and the child's attendance at scheduled sessions.

CLIENT CONSENT TO TREATMENT

I have received and carefully read the Informed Consent Agreement carefully; I understand them and agree to comply with all of the policies and procedures described in these documents.

____ ________________

Client #1 Name (please print) Date

____ ________________

Client #2 Name (please print) Date

Client Signature #1 | Date

Client Signature #2 | Date

Parent/Guardian Signature | Date

Counselor/Therapist Signature | Date