*Jill R. Stevens, MA, LCPC*

# INFORMED CONSENT

I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws, and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. Today's appointment will take approximately 60-90 minutes. You are entitled to know my professional credentials, which are as follows. I earned a Bachelor of Arts Degree in Psychology, with highest honors, from the University of Tennessee, Knoxville and a Master's Degree in Clinical Psychology from Southern Illinois University at Carbondale. I am licensed by the State of Illinois as a Licensed Clinical Professional Counselor, #180-004411. I have over 20 years of clinical experience in treating adults. Treatment practices, philosophy, and plan limitations and risks will be discussed with you today.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS**: Your verbal communication and clinical records are strictly confidential except for:

- information (diagnosis and dates of service) shared with your insurance company to process your claims
- information you report about abuse or neglect of a child, which I am obligated by Illinois state law to report to the IL Department of Children and Family Services
- information you report about abuse or neglect of person aged 60 years or older, which I am obligated by Illinois state law to report to the IL Department of Aging
- where you sign a release of information to have specific information shared
- if you are in imminent and foreseeable danger of seriously harming yourself or others
- information necessary for case supervision or consultation
- when required by law

If an emergency situation for which the client or their guardian feels immediate attention is necessary, you or your guardian may call my cell phone, 618-713-5672. If you leave a message, please indicate if it is an emergency. If your emergency call is not returned within 15 minutes, please understand that you or your guardian are to contact the emergency services in the community (911, hospital emergency room) for those services. I will follow those emergency services with standard counseling and support.

***Client Signature:*** ___________________________________________***Date:***________

***Witness Signature:*** _________________________________________***Date:***_________

**FINANCIAL/INSURANCE ISSUES:** As a courtesy, I will bill your insurance company, HMO, responsible party or third party payer for you if you wish. I ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your

deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, I request that you pay the balance due at that time. If your balance exceeds $300, I will need to ask that you pay for services when rendered. I ask that every client authorize payment of medical benefits directly to Jill R. Stevens, M.A., LCPC.

***I have received a copy of the fee schedule.***

***Client Signature:* _________________________________________*Date:*________**

***Witness Signature:* ______________________________________*Date:*_________**

Lastly, if you need to cancel or reschedule an appointment, please give 24 hours advance notice whenever possible, otherwise you may be <u>billed at the hourly rate</u>. I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments, please feel free to ask. **You may have a copy of this form if requested.**

***Client Signature*__________________________________________*Date*__________**

***Witness Signature:* ______________________________________*Date:*_________**

**<u>COORDINATION OF TREAMENT:</u>** It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that I have acted in reliance on such authorization**. If you prefer to decline consent, no information will be shared.

**____You may inform my physician(s)    ____I decline to inform my physician**

**PHYSICIAN NAME:_________________________________________________**
**CLINIC:____________________________________________________________**
**ADDRESS:_________________________________________________________**
**PHONE:_____________________________________**

**PHYSICIAN NAME:_________________________________________________**
**CLINIC:____________________________________________________________**
**ADDRESS:_________________________________________________________**
**PHONE:_____________________________________**

***Client Signature*__________________________________________*Date*__________**

***Witness Signature:* ______________________________________*Date:*_________**

**HIPPA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES AND CLIENT RIGHTS**

*I have read and received a copy of the HIPPA Notice of Health Information Privacy Practices and Client Rights document.*

***Client Signature*____________________________________________*Date*__________**

***Witness Signature:* ________________________________________*Date:*_________**