INFORMED CONSENT

Thank you for choosing Rebecca Malley, LCPC for your counseling needs. 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. I have earned a B.S. Degree in Psychology from Bradley University and a M.A. in Counseling from the Adler School of Professional Psychology. I am licensed by the State of Illinois as a Licensed Clinical Professional Counselor. I have over 10 years of clinical experience in treating adults who suffer from depression, anxiety, trauma issues, and other mental health issues. I use a client centered approach, Cognitive Behavioral Therapy, and EMDR as appropriate. Other treatment approaches may be used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you as part of your treatment.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. In the unlikely event that I am unable to provide ongoing services Courtney Bowman, LCPC will provide those services or link you to appropriate services. She will maintain your records for a period of 7 years. Courtney Bowman, LCPC may be contacted by phone at (630)935-1638 or by email at ctepler@gmail.com. In an emergency situation for which the client or their guardian feels immediate attention is necessary, please call Rebecca Malley, LCPC immediately. If no follow-up call from Rebecca Malley, LCPC is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Rebecca Malley, LCPC will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond. Rebecca Malley, LCPC may send you forms or information about appointment/billing issues through e-mail, but I will not discuss clinical information with you through e-mail, text, or social networking sites.*

***Signature(s)*_____*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 if you are using insurance. If you are not using insurance, I ask that you pay the full fee we have agreed upon at the time of each session. In the event you have not met your deductible, I will charge you the rate contracted with your insurance company 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. After 60 days any unpaid balance will be charged 1.5% interest per month (18% APR). In the event that an account is overdue and turned over to a collection agency, the client or responsible party will be held responsible for any collection fee charged to my office to collect the debt owed. I ask that every client authorize payment of medical benefits directly to Rebecca Malley, LCPC
I have received a copy of the fee schedule _____

I will bill your insurance company as a convenience to you, if you give written consent. Payment from your insurance will be made to Rebecca Malley, LCPC.
I give written consent for insurance billing _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be <u>billed at the hourly rate</u>. I sincerely appreciate your cooperation and if 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.***

Signature(s)_____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:_____
Signature(s)_____Date_____

<u>NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS</u>:

I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.
Signature(s)_____Date_____