Whitesell and Associates, LLC

Client Name: _____ DOB:_____

Welcome to Whitesell and Associates, Inc. We appreciate your trust and the opportunity to help you. Please read and sign this office policy statement to indicate your consent to treatment and understanding of our office procedures.

CLIENT/THERAPIST RELATIONSHIP: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most 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. Gifts are not appropriate, nor are any sort of trade of service for service.

AVAILABLE SERVICES: Whitesell and Associates, Inc. offers a wide array of counseling services, including individual, family, couples and group services. We are staffed by skilled and experienced licensed clinical professional counselors, psychologists, and clinical registered and/or certified art psychotherapists. Effective psychotherapy or treatment is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

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

COUNSELING: We provide short-term counseling designed to address many of the issues our clients are dealing with. Your first and possibly second visit will be assessment sessions in which you and your therapist will determine your concerns, and if both agree that Whitesell & Associates, Inc. can meet your therapeutic needs, develop a treatment plan. Should you choose not to follow the plan of treatment provided to you by your therapist, services to you may be terminated.

The goal of therapy is to provide the most effective therapeutic experience available to you. If at any time you feel that you are your current therapist are not a good fit, please discuss this matter with your therapist to determine if transferring to a more suitable therapist is right for you. If you and your therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

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

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 45 – 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your therapist. If you must cancel or reschedule your

appointment, we ask that you call us at 410-914-4012 twenty-four (24) hours in advance with no penalty. This will free your appointment time for another client. Under 24 hours of notice there is a $60 missed appointment/late cancel fee.

FEE SCHEDULE: Diagnostic and Evaluation Session **$150.00**
Regular Office Visits (Individuals, Couples, & Art Therapy) **$125.00**
**Please note that fees do not apply to Medicaid clients*

EMERGENCIES: You may encounter a personal emergency, which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately; however, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, your therapist's cell number will be given to you. Please utilize this direct number in the event of a crisis, and your therapist will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your therapist is out of town, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: Your practitioner follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your treatment. 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. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; 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 disclose; fee disputes between the therapist and 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 the attention of the therapist when you and the therapist discuss this matter further. 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, and 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 my consent to my therapist to contact any 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 call any medical or law enforcement personnel deemed appropriate.

INCAPACITY OR DEATH: I understand that, in the case of death or incapacitation of the undersigned therapist, it will be necessary to assign my case to another therapist and for that

therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

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), and my spouse or family and I understand that I may stop such treatment or services at any time.

NOTE: If you are consenting to the treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, the therapist will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Partner/Parent Date

_____ _____

Therapist Date

Acknowledgement of responsibility: I understand and acknowledge that payment is due at the time of service unless payment arrangements from a third party have been approved in advance. I understand that I am financially responsible for all charges not paid by my insurance company, unless they are not contractually chargeable to me.

Individual Insurances/managed care/third party plans: I hereby authorize Whitesell & Associates, Inc. to release information necessary to secure the payment of third party payments. I further authorize payment to Whitesell & Associates, Inc. I authorize to use my signature as necessary to obtain the payment of third party payments.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Partner/Parent Date

Copies may be requested of this signed form at any time.

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Fax: (443) 817- 0808