DISCLOSURE/CONSENT FOR TREATMENT

DISCLOSURE AND CLIENT CONSENT: Please read and initial each designated section stating you have read and understand the information below.

Disclosure Statement

Thank you for choosing Renewed Life and Hope, LLC. Today's appointment will take approximately 45-50 minutes. I realize that starting counseling is a major decision and you have may have many questions. This document is intended to inform you of my policies regarding financial matters, confidentiality, other administrative issues, state and federal laws and your rights as a client. I will need to have you sign and date this disclosure in order to begin the counseling process. If you have any questions or concerns, please ask and I will try my best to give you all the information you need. Remember, you are coming to me to seek assistance that helps you learn how to control your own life.

Florida 64B4-31.009 Treatment by a Mental Health Counselor: Mental health counseling treatment as contained in subsection 491.003(9), F.S., is distinguished by the use of methods of a psychological nature to evaluate, assess, diagnose, treat, and prevent emotional and mental disorders and dysfunctions, whether cognitive, affective, or behavioral, sexual dysfunction, behavioral disorders, alcoholism, and substance abuse.

My Therapeutic Approach:

My primary identity is as a Pastoral Mental Health Counselor. This means that I use a very relational and pastoral approach to my thinking and counseling. The foundation of my understanding of the human person is based on a well-grounded Christian anthropological view of the person and their inherent dignity and worth as a child of God. I believe that the human person is relational, made for community, and is most fully alive when in communion with others. A central focus of my work with clients is directed toward developing authentic, genuine and reciprocal relationships.

I believe that health is optimized when there is a balance and integration of body, mind, and spirit. 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 the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide clients an integrated solution for their mind, body, and spirit to enhance their lives and resolve issues. Some situations and problems have a physical component that is beyond a relational dynamic. To the best of my ability I will work to recognize these and medical consultation will be advised.

In addition to pastoral-relational skills I utilize my knowledge of the behavioral and medical health sciences to best integrate psychology with faith and spirituality. This allows me to use a variety of theoretical orientations that honor the unique and individual need of each client. This includes but is not limited to the following therapeutic techniques and treatment methods: psychodynamic, narrative, cognitive-behavioral, rational-emotive, family systems, client-centered and brief solution-focused therapy, EMDR therapy, and Lifespan Integration Therapy. I offer individual and couples therapy.

Although grounded in my own Christian faith tradition I welcome clients from diverse faith backgrounds. Initial: _____

Risk and Benefits of Counseling:

I believe that therapy is a unique and highly individual experience. The outcome of therapy will greatly depend on the motivation and effort you bring to the therapeutic setting. Counseling/Therapy is beneficial, but as with any treatment, there are inherent risks. During counseling, 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, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. No counselor can guarantee these benefits, of course. It is my desire, however, to work with you to attain your personal goals for counseling.

DISCLOSURE/CONSENT FOR TREATMENT

The length of therapy will vary among clients. Therapy can be as brief as 8 to 16 weeks or as long as 2 years depending on the underlying issues the client (s) wish to address. Change normally occurs gradually over a period of time. Initial_____

Education and Training:

I am a Licensed Mental Health Counselor in the State of Florida. My license number is MH 13443. I received my MA degree in Pastoral Counseling/Mental Health Counseling from Seattle University in 2010. My academic training also included an eighteen month counseling internship at a community mental health agency. I obtained my BS in Psychology and Health Management from Excelsior College in New York and my Associate Degree in Applied Science/Nursing from Edison State College in 1979. I continue to hold a valid WA State Licensed Mental Health Counselor (LMHC) license (LH 60339471). I also hold a valid Florida State RN license (RN 1090212). I am a certified Spiritual Director having obtained training and certification in 1999 through the School of Spirituality in Clearwater Florida, an affiliate of Franciscan University.

Initial: _____

Client Rights and Responsibilities:

As a client it is always your right to choose your therapist and the type of therapy you feel will best meet your needs. In this regard I consider myself very client-centered. You will always have the right to ask questions or address your concerns at any time during the process. If for any reason you feel that my approach is not beneficial I encourage you to discuss this with me. You have the right to request a different approach or even a referral to another therapist if you feel that we are unable to reach a mutually satisfying solution that will work for you.

It is also your right as a client to terminate therapy at any point in time. It is my hope however that we would have an open discussion and work towards finding a solution before you make the decision to abruptly terminate therapy.

As a client you have the right to respect and confidentiality. I take this very seriously and will do all that I can to protect your privacy.

As the client your participation in the counseling process is essential for a positive outcome and for attaining your desired goals. It is your responsibility to arrive on time for each counseling session and to make each scheduled appointment. Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an extended session can be discussed and negotiated if I determined this to be appropriate. I keep your appointment time specifically for you and as such expect you to honor the time commitment. If for some reason you need to cancel and reschedule your appointment please notify me at least 24 hours in advance. Failure to do so could result in you being charged the full rate for the missed appointment.

If you arrive late for a session I am not able to make up the extra time as other clients may be scheduled. A phone call or phone message is considered adequate notice, an email or text message is not. Please call 239-677-8921 if you need to cancel and I will get back with you so we can reschedule.

Like many therapist I seek consultation when I feel that another perspective would benefit my work with you. Identifying information is never disclosed and confidentiality is always strictly maintained between therapist, supervisor/consultant.

Initial_____

Limits of Confidentiality:

I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions provided to you and as listed below:

Florida Statutes Regarding Confidentiality:

DISCLOSURE/CONSENT FOR TREATMENT

491.0147 Confidentiality and privileged communications—Any communication between any person licensed or certified under this chapter and her or his patient or client shall be confidential. This secrecy may be waived under the following conditions:

(1) When the person licensed or certified under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.

(2) When the patient or client agrees to the waiver, in writing, or, when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.

(3) When, in the clinical judgment of the person licensed or certified under this chapter: There is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed or certified under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities. There shall be no liability on the part of, and no cause of action of any nature shall arise against, a person licensed or certified under this chapter for the disclosure of otherwise confidential communications under this subsection.

The client understands and agrees that the therapist's working notes are not considered part of the clinical record and will not be released to the client or to any other persons, agencies, or organizations under any circumstances. The client understands and agrees that any records obtained from other therapists, agencies, or institutions also will not be released by the therapist under any circumstances. The therapist will respond to any court order for records by providing only the dates of treatment or contacts with the client and a general summary of counseling activity. The therapist will have broad discretion to release any information she deems relevant in situations where she believes the client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect. If you have any questions regarding confidentiality, you should bring them to my attention so we can discuss them further. By signing this Information and Consent Form, you are giving consent to me to share confidential information with all persons mandated by law. Initial: _____

BILLING/FEE SCHEDULE:

Individual Session (50 minutes)	$100.00
Individual Session (90 minutes)	$140.00
Couples Session (50 minutes)	$130.00
Couples Session (90 minutes)	$165.00
Returned check fee per check	$25.00

I re-evaluate my fee scale each year on January 1st. My fees will not increase by more than $10.00/50 minute session for existing clients. A reasonable fee will be charged for copies of records requested by client. Initial: _____

CANCELLATION POLICY:

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment. Thank you for your consideration regarding this important matter. Initial: _____

PAYMENT/INSURANCE FILING:

DISCLOSURE/CONSENT FOR TREATMENT

Payment of fees is expected at the time of each appointment. I request that payment be made before your session begins. I do not file insurance claims on your behalf. You may be entitled to reimbursement from you insurance company if you have counseling/mental health benefits. I can provide you with a monthly record/receipt which will include a procedural code and diagnostic code if necessary in addition to the date and time of each counseling session you attended. Once this information is released to you for filing your insurance claims I assume no responsibility for the continuation of confidentiality.

Initial: _____

EMERGENCIES:

You may encounter a personal emergency which will require prompt attention. If an emergency arises, or if you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. For all mental health crises you can call the county designated crisis line:

I do not provide immediate crisis intervention services. During regular office hours you may contact me regarding the nature and urgency of the circumstances. I 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, I will make every effort to respond in a timely manner. Initial: _____

CONTACT INFORMATION

I am my own Privacy Officer. If you have any questions about this Notice of Privacy Practices, please contact me. My contact information is: Colleen Tredway, MAPC, LMHC 13443 239.677.8921

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 I understand that I may stop such treatment or services at any time.

My therapist and I have agreed on the following fee: $_____per 50 minute/hr. $_____per 90 minute /hr.

I/We will be participating in: _____ individual _____ couples therapy.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature – Spouse/Partner/Parent Date

_____ _____

Therapist Date