Hope Restored Counseling OF FLORIDA LLC

Informed Consent

The following information is provided to acquaint you with the office procedures and to better assist you with the therapeutic process.

_____ 1. **Your Rights as a Client**
(initial)

I. You have the right to ask questions about any therapeutic process at any time during therapy.
II. You have the right to decide at any time to no longer receive services from ***Hope Restored Counseling of Florida, LLC.*** If needed, a referral to another therapist can be provided.
III. You have the right to end therapy at any time without moral, legal, or financial obligations (other than those already incurred). And without repercussion.
    a. If you are ending therapy services because you are not satisfied with the therapeutic process, we ask that you give us the opportunity to discuss this with you.
IV. You have the right to expect that I will maintain professional and ethical boundaries in accordance with the Social Work's Code of Ethics. Therefore, we will not enter in to any personal, financial, or professional relationships with you.

_____ 2. **Confidentiality**
(initial)

I. Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be released without your permission.
II. There are certain situations in which we, as a mental health professionals, are required by law to release information. These situations include:
    a. If you threaten bodily harm or death to another person, we are required by law to inform the intended victim and appropriate law enforcement agency.
    b. If you threaten bodily harm or death to yourself, we are required to contact the appropriate law enforcement agency.
    c. If you reveal information related to abuse or neglect against a child, dependent adult, or elderly person, we are required by law to report this to the appropriate authorities.

_____ 3. **Social Media:**
(initial)

I. We do not accept friend requests from any current or former clients on any social media sites. Communicating via social media is considered unethical within the social work field, as it may compromise your confidentially and the therapeutic process. Therefore, please do not be offended that if you were to send a friend request it will be denied.
II. You have been provided a copy of the **Social Media and Technology Communication Policy** and are responsible for reading.
III. You are responsible for asking questions if you do not understand the **Social Media and Technology Communication Policy**.

_____ 4. **Benefits and Risks of Therapy:**
(initial)

Psychotherapy is a process in which you and your therapist discuss a variety of issues, events and experiences for the purpose of creating positive changes, so that you may experience your life more fully. Participating in therapy may result in several benefits to you, including but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, and increased self-confidence. There is, however, no guarantee that therapy will yield any or all these benefits.

Participating in therapy may also involve some discomfort, including remembering and discussing unpleasant events, feelings, and/or experiences. The process may evoke strong feelings of sadness, anger, fear, etc. The issues presented by you may result in unintended outcomes, including changes in personal relationships. During the therapeutic process, many clients find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times but may also be slow and frustrating. Please address any concerns you have regarding your progress in therapy with me.

_____ 5. **Therapy Services and Fees:**
(initial)

I. An individual therapy session is approximately 45 to 50 minutes long. If you desire longer sessions, please discuss this with us in advance.
II. An individual nutrition counseling session is an (1) hour for the initial session and 30 minutes for any follow up sessions.
III. How often sessions take place will be discussed and agreed upon.
IV. If you are unable to attend your scheduled appointment, you must notify the office **no less than 24 hours,** before your session. ***Failure to cancel your appointment on time will result in you being charged the full rate for that session*.**
V. Payment is required at the time of your appointment. If at any point in the course of therapy you are unable to pay your fees, please communicate this and if possible, a sliding scale may be arranged.
VI. We only see self-pay clients. We do not bill insurance companies. The necessary reimbursement form will be provided at your request.
VII. Only cash, credit or debit card payments are accepted. Flexible Spending Cards (FSA) cannot be used to pay for sessions. You will need to seek reimbursement from the FSA provider. A statement can be provided at your request.
VIII. If you need to pay via check, please communicate this in advance. You will be responsible for any nonsufficient fund (NSF) fees in the event the check does not clear the bank. The current NSF fee is $30.00.
IX. You are required to have a valid debit or credit card on file with our office.
X. If at any time we cancel an appointment with less than a 24-hour notification you will be provided with one (1) 45 to 50-minute counseling session at **no charge** to you.

_____ 6. **Email and Phone Communication between Sessions:**
(initial)

I. Email and phone communication are typically reserved for scheduling communications only. The confidentiality of email cannot be guaranteed. We do not conduct therapy by email. We typically respond to email within 48 hours during the work week (Monday through Friday), unless the office is closed, which you will be provided with notifications, in most cases.
II. The 863.712.0877 number is a cell phone therefore, you may call or text as needed to cancel or reschedule appointments.
III. **If you are in crisis, please contact the local crisis hotline 863.519.3744 or 800.627.5906.** We do not provide crisis counseling between sessions.

_____ 7. **HIPAA Privacy Notice:**
(initial)

I. You have been provided a ***Notice of Privacy Practices*** and are responsible for reading.
II. You are responsible for asking questions if you do not understand the Privacy Practices.
III. You have the right to file a complaint if you choose without any retaliation. The information to file a complaint is provided in the ***Notice of Privacy Practices***.

The effective date of the HIPAA Privacy Notice is February 01, 2019

By signing this Informed Consent, you acknowledge that you have read and understand this document in its entirety, and you agree to the terms and conditions set for obtaining therapy through **Hope Restored Counseling of Florida, LLC**. If there is anything you do not understand please discuss it with us prior to signing.

Client Signature: _____ Date: _____

Client's Printed Name: _____

Therapist Signature_____ Date: _____