Hillcrest Therapy Center

INFORMED CONSENT

I am voluntarily seeking counseling for my particular issue(s) and I am committed to working with my therapist to successfully resolve my issue(s). I realize that counseling can be beneficial both for me and those with who I am in relationship, but that it comes with no guarantees. While self-disclosure of relevant information is beneficial to the counseling process, I also understand that counseling may involve discussing relationship, psychological and/or emotional issues that may, at times, be distressing. I understand that my situation and/or emotional/mental state may get worse before it gets better due to the distress that may be experienced throughout the process of therapy. I am aware of alternative treatment methods available to me.

My therapist/counselor will meet with me regularly, listen attentively, work with me to accomplish mutually stated and agreed upon goals. My counselor will treat me with respect and dignity. I understand that my counselor is bound by the legal and ethical standards of his/her profession. This includes confidentiality, which means that my counselor will not reveal any information about me except in the following situations:

Medical Emergency
Threats of Suicide, Bodily Harm to Self or Others
Suspected Child Abuse or Neglect; Suspected Abuse of the Elderly or Disabled

I understand that I have a right to review my records at any time, and that if I have questions or concerns I can reach my therapist through the contact information provided for me. In case of an emergency, I will call 911. Should my therapist become incapacitated, an authorized person will contact me and may refer me to another therapist. My records will continue to remain confidential unless otherwise authorized by me.

Payment is expected on the day that services are rendered. This includes any co-pay for insured clients and the entire session fee for private-pay clients. I will notify my counselor at least 24-hours before my appointment if I need to cancel or reschedule my session, otherwise I will be billed for that appointment at a reduced rate of $50. I give my therapist permission to contact me through the information I have provided on my Client Information Form. I understand that e-mail correspondence may not always be a secure/confidential means of communication.
My therapist has answered all my questions about counseling satisfactorily. If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave counseling at any time, although I have been informed that this is best accomplished with my therapist.

I have read, understood and agree to the above.

_____ _____
Client Date

_____ _____

5506 W. Markham St., Little Rock, AR 72205 | 501-612-7254 | www.hillcresttherapycenter.com | 888-236-4389 (fax)

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Parent/Guardian if client is a minor Date
I have reviewed the above information with my client.