Thrive Life Counseling and Wellness, LLC

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Licensed Mental Health Counselor
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Client Informed Consent

This form is provided in order to help you understand several important things about your counselor's professional status and qualifications, your professional relationship with your counselor, and your rights as a client. Please read all information carefully. Feel free to ask questions about anything you do not understand.

Counselor Status and Qualification: I am a Licensed Mental Health Counselor, hold a Master's Degree in Counseling Psychology, and a Bachelor Degree in Social Work. I have several years of experience working in various mental health positions, including clinical counseling and social work. I authored a book titled The Thrive Life in 2014 that uses therapeutic concepts and goal setting to help people make real and lasting change in their life.

Counseling Relationship: During the time we work together, we will usually meet weekly for 45-50-minute sessions. Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Please do not invite me to a social event, bring gifts, ask to barter or exchange services, ask me to write references for you, or ask me to relate to you in any way other than the professional context of our counseling relationship. You will be best served if our interactions address your concerns exclusively.

I conduct all counseling sessions in English or with a translator for whom you arrange and pay. I do not discriminate on the basis of race, gender, religion, national origin, sexual orientation, or physical disability. If significant differences, such as in culture or belief system, exists between us, I will work to understand those differences. Unless you prefer otherwise, I will call you by your first name; please call me Thomas.

Effects of Counseling: Although I expect you to benefit from counseling, I cannot guarantee any specific results. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or

understanding of yourself. You may feel distressed, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. In particular, one risk of couples counseling is the possibility of exercising the divorce option. Although the exact nature of changes resulting from counseling cannot be predicted, I intend to work with you to achieve the best possible results for you. If you are dissatisfied with me at anytime, I ask that you address these concerns with me, and if we cannot come to a solution you are happy with, I can refer you to another counselor. If you need to reach me outside of the counseling session, please leave a message at 850-890-7963, and I will get back to you as soon as possible. **If it is an emergency, please call 911.**

Fees: In return for a previously agreed upon fee of $125.00 per session, I agree to provide counseling services for you. If the fee represents a hardship to you, please let me know. The fee for each session will be due and must be paid either before or immediately after the session (unless previous arrangements have been made). Cash, Credit Card or personal checks made out to "Thrive Life Counseling and Wellness, LLC" are acceptable for payment. I am working on becoming a provider for several insurance companies and will file the claim on your behalf, but you are still responsible for the fee if the insurance company refuses to pay any or part of the amount owed unless other arrangements have been made prior to the session. If I am an out of network provider for your insurance provider you may request a "superbill", which is a form I would give to you for you to submit to your insurance company for potential reimbursement.

Confidentiality: Discussion between the two of us, and even the fact that you are counseling with me, is confidential. For that reason, if I see you in public I will protect your confidentiality by greeting you only if you greet me first. While confidentiality is of us the utmost importance to me, there are limits. These conditions include, but are not limited to, the following situations: a) you and your legal representation direct or consent in writing that I release your records; b) I am consulting with another mental health professional about how to best serve you, in which case I will not use your name or will use your first name only; c) I learn that you are involved in abuse, neglect, or exploitation of a child, elderly, or disabled person or a patient in a mental health facility; d) I learn that you are infected with a potential life-threatening illness that could be transmitted to a specific uniformed person; e) you disclose sexual contact with another mental health professional with whom you had a professional therapeutic relationship. In that case I must file a complaint and have a right to confidentiality in the filing of the complaint; f) I am testifying in a child custody or visitation case involving you; g) I am testifying in a lawsuit in which your mental health is an issue; h) You have been charged with a crime; i) You bring a negligence suit against me; j) I am

ordered by a Court to disclose information; or k) I am otherwise required by law to disclose information.

In the event that I believe you are in danger, physically or emotionally, to yourself or another person, you specifically consent for me to warn the person and to contact the following, in addition to any medical and/or law enforcement personnel:

Emergency Contact:

Name_____ Telephone Number_____

If at any time you have any question regarding confidentiality, you should bring them to my attention. By signing this information and consent form, you are giving consent for me to share confidential information with all persons mandated by law, with the agency or mental health professional who referred you, and with my supervisor. You are also releasing me and holding me harmless from any departure from your right of confidentiality that may result.

Records: All of our communication becomes part of the clinical record, which is maintained in the form of paper files. Records are property of Thrive Life Counseling and Wellness, and stored in a lockable file cabinet. Adult client records are destroyed seven years after the file closed. Minor client records are destroyed seven years after the client's 18th birthday.

Consent to Treatment: By your signature below, you are indicating; 1) that you voluntarily agree to receive a mental health assessment and mental health care, treatment, or services, and that you authorize me to provide such assessment and care, treatment, or services as I consider necessary and advisable; 2) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such care, treatment, or services that you receive through me; 3) that you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you; and 4) that I provide you with a copy of this statement. By your signature, you verify the accuracy of this document and acknowledge your commitment to its specifications.

_____	_____	_____
Print Name	Signature	Date

_____

Street Address

_____

City, State Zip code

_____

Phone Number