REILLY COUNSELING CENTER
INFORMED CONSENTS

Discussions between Reilly Counseling Center counselors, staff, and clients are mostly safeguarded. Usually, no information will be released without the client and/or legal guardian's written authorization unless the information is released to contracted agencies, or as mandated to be released by law.

Other exceptions to confidentiality include, but are not limited to, the following situations:

- Imminent and substantial danger to yourself or others.
- Abuse or neglect of a child or of an elderly or disabled person.
- Criminal prosecutions against Reilly Counseling Center or its representatives.
- Subpoena or judge's order.
- Civil lawsuits brought against Reilly Counseling Center or its representatives, by you or your family for any reason.
- Situations in which the Reilly Counseling Center counselor has a duty to disclose; or per the counselor's or Reilly Counseling Center representative's judgment that it is necessary to warn or disclose in an emergency situation.
- Fee disputes between the counselor and you and/or the family member seeking services (i.e. collection agencies).
- Licensing, certifying, professional association, state department, or governmental entity review boards which are investigating a complaint against Reilly Counseling Center or its licensed representatives.
- All persons and agencies mandated or authorized by law.
- Managed care and/or insurance carrier including, but not limited to, Medicaid, private insurance, or other third party payers responsible for providing my and/or my family member(s) care or services and payment for those services.

If you and/or your family members have any questions regarding confidentiality, please refer to the Volunteers of America Notice of Privacy Practices, and bring them to the attention of the counselor for further clarification.

Risks of Treatment

You will be making decisions in conjunction with the counselor about what services you will receive. While receiving these services you and/or your family member(s) may learn things about each other or yourselves that you and/or they do not like. The success of counseling depends on the quality of efforts on the part of both the counselor and the client(s), and the realization that you and/or family member(s) are responsible for lifestyle choices/changes that may result from treatment. Specifically, common risks include: couples exercising the option of divorce; children or adolescents becoming angry with parent(s), caregiver(s), or other family members; anxiety; depression; fear; emotional pain and distress; suicidal and/or homicidal ideations, plans, or behavior; treatment failure; an increase in medical, psychiatric, psychological, and social symptoms.

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A VOLUNTEERS OF AMERICA ENTERPRISE

Consent to Contact for Appointment Changes

I specifically consent for the counselor or Reilly Counseling Center staff to contact me by telephone and/or mail, including leaving a message via answering machine or voice mail, or text.

After Hours Emergencies

Emergencies are urgent issues that require immediate action. Reilly Counseling Center does not have a crisis hotline. Clients are encouraged to contact 911 in case of emergency.

Staff Incapacity, Death, or Separation

I acknowledge that, in the event that the counselor becomes incapacitated, dies, or separates from Reilly Counseling Center it will become necessary for another Reilly Counseling Center staff to take possession of the case, file, and records. By signing this Declaration of Informed Consent form, I give my consent allowing another representative selected by the program to take possession of the case, file, records, if necessary, in order to complete, or continue to provide services through Reilly Counseling Center, or in order to deliver a copy upon my request to an outside agency, so that they may complete or continue services. Please be advised that you will potentially be charged fees for the copying, labor, and postage of any such files or records if the case is transferred at your request to an outside professional.

Length of Visits

Appointments will vary in length depending on the service provided. Assessment and individual counseling appointments are typically 50 minutes to one hour in length. Specialized treatment methods, such as EMDR, may require more time than typical. Fees are charged per session, not length of session.

Relationship

Your relationship with the counselor is professional and therapeutic. In order to preserve this relationship, it is imperative that the counselor does not have any other type of relationship with you and/or your family. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Gifts, bartering, and trading services are not appropriate, and should not be shared between you or your family and the counselor.

Payment for Services

The charges for services will be billed to your insurance, if applicable. Otherwise, your fee is determined by the Volunteers of America Sliding Scale Fee Schedule if you are unable to afford the payment rate. We will expect full payment of your account, and you will be responsible for payment of the insurance co-payment, session fee, or sliding scale fee, at the time that services are rendered. Please be advised that various insurance plans require different co-payments. Your co-payment is based on the mental health policy selected by your employer or purchased by you. In addition, the co-payment may be different for the first visit than subsequent visits. You are responsible for and will be expected to pay your co-payment before services are provided. It is recommended that you determine your co-payment before your first visit by calling your benefits office or insurance company.

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Cancellations

Cancellations must be received at least 24 hours before the scheduled appointment. You are responsible for calling to cancel or reschedule the appointment.

Payment for Records/Testimony

Although it is the goal of the counselor and Reilly Counseling Center to protect the confidentiality of your clinical records, there may be times when disclosure of records or testimony will be compelled by law. In the event the law requires disclosure of records or testimony, you may be responsible for paying the costs involved in producing the records. Such payments are to be made at the time, or before the time, the counselor or Reilly Counseling Center staff render the services.

General Consents

- I consent to the use, disclosure, or receipt by Reilly Counseling Center of health information about me, including information pertaining to mental health and/or related condition for the following purposes: treatment, payment, and health care operations.
- I understand the limits of confidentiality and all of the releases signed in this document.
- By signing this Declaration of Informed Consent, I (the undersigned client, child, adolescent, parent, and/or legally authorized representative) acknowledge and certify that I have been given a copy of the "Notice of Privacy Practices", I have read or have had it read to me, and that I understand the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.
- I authorize Reilly Counseling Center to provide counseling services to myself and/or my child (children). I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and have completed the form. I certify that this information is true and correct to the best of my knowledge. I will notify Reilly Counseling Center staff of any changes in provided information that may occur in the future.

Client _____ **Date** _____

Reilly Counseling Center Staff _____ **Date** _____

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ADDITIONAL INFORMATION FOR CHILD/ADOLESCENT

Child/Adolescent's Name:_____
DOB:_____ Age:_____ Social Security Number:_____
School: _____ Grade Level:_____

Custodial Parent(s):_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Please indicate which phone number you would prefer us to use to contact you _____

If divorced, Non-custodial parent(s):_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Year Divorced:_____ Age of Child at Time of Divorce:_____

***Please provide documentation from Divorce Decree stating who has legal authority to consent to mental health counseling services.**

Please list all siblings of child/adolescent:

_____ Age_____ Male / Female
_____ Age_____ Male / Female
_____ Age_____ Male / Female
_____ Age_____ Male / Female

GUARDIAN'S CONSENT FOR TREATMENT

I acknowledge that I, _____, am the legal guardian of _____ _____. I hereby give my consent for him/her to receive counseling services with Reilly Counseling Center. Treatment may include individual and/or family therapy, play therapy, Parent-Child Interaction Therapy, or other therapy modalities as indicated by the Reilly Counseling Center counselor. I realize that at all times the nature and content of such services must remain confidential.

Signature of Client or Policyholder:_____ Date:_____

Please print name:_____