INFORMED CONSENT FOR COUNSELING SERVICES

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Baltimore, MD 21211

Introduction: This informed consent document is intended to give you general information about the counseling services you are beginning today. We will discuss the content and any questions you might have after you have had a chance to read it carefully.

Therapy is more likely to be successful if we can build a relationship that begins with clearly defined rights and responsibilities held by each of us. This will help us to create a safe environment to take risks and to find the support needed to become empowered to change. As a client in counseling, you have certain rights and responsibilities that are important for you to know about because this is your therapy, concerned with your well-being. It is also important for you to be aware of certain limitations to those rights.

Therapy Services: I understand that after today's initial session we will work together to set goals that I would like to reach in counseling, and to determine the best therapy approaches to use to accomplish my goals. I further understand that making progress toward my therapeutic goals is most likely if I commit to a minimum of 12 consecutive weeks of counseling, and to being open and honest with the counselor. Also, I understand that appropriate referrals will be provided to me if it is determined that I would be best served by another counselor or community resource. I also understand that an important factor in moving toward my goals in counseling is a commitment to being honest and open.

Cost of Therapy: I understand that I am responsible for the cost of therapy, and agree to pay at the time of service. I agree to pay $100 per 50-minute individual sessions; and $40 per-100 minute group therapy session.

Attendance: I agree that I will notify the counselor **at least 24 hours** in advance if I know I will miss a session, understanding that ongoing commitment and responsibility to the therapeutic process is important factor in making progress toward my counseling goals. Further, I understand that I will be charged the full fee for scheduled appointments I do not attend unless, I call to cancel or reschedule **at least 24 hours** prior to the appointment.

Confidentiality: I understand that with some specific exceptions described below, I have a right to confidentiality. With the exception of talking with her supervisors, the counselor will not tell anyone else what we discuss, or indicate to anyone that I am receiving counseling services without my prior written permission. I also understand that at anytime, I can change my mind, and revoke any permission I grant to release information related to the therapy I am receiving.

I understand that the following exceptions to confidentiality will be reported as required by law:

1. A serious issue of harm to yourself or others;
2. Indications of abuse or neglect of children; and
3. Indications that a vulnerable adult has been subjected to abuse, neglect, or exploitation.

Emergency Procedures: Individuals who are experiencing an emergency should call 911, or the Maryland Crisis number at 1-800-422-0009.

Benefits & Risks of Therapy: I understand that participation in counseling may increase personal challenges that, while intended to produce changes and improve my life, can initially cause some difficulty or disruption for me. Counseling may also contribute to unanticipated changes in my feelings, values and attitudes, and may have unexpected impact on current relationships. Participation in therapy may improve my ability to interact with others, provide me with more understanding of myself and give me additional coping skills.

Other Rights: I have the right to ask questions about anything that happens in counseling. The therapist is always willing to answer any questions I have, and to look at alternatives that might work better.

Termination Policy: I understand that counseling will terminate when I have met the goals I set, or when either my counselor or I feel that therapy is no longer beneficial. Should you be interested in referral to another therapist you will be provided a list of at least three therapists.

Consent

I certify that I have read, understand, and agree to abide by the information outlined above regarding my therapy. I hereby give my consent to authorize Theresa Robertson to assess, treat, and/or refer me to others as needed. I have had the opportunity to discuss any questions regarding the above information.

*Signature:*_____ *Date:*_____

*Name (Printed) :*_____

*Therapist Signature:*_____ *Date:*_____

*Therapist Name (Printed):*_____