**Rebecca English Counseling**

**Statement of Informed Consent for Adults**

I (Client name) agree and give consent for psychotherapy and treatment by Rebecca English Counseling. I understand that there are certain risks involved, such as being willing to disclose personal information and be open and honest with the therapist. I understand that I have entered into this therapeutic relationship voluntarily and may terminate treatment at any time, however there might be risks involved in terminating treatment early. The scope and nature of this treatment has been explained to me and I understand that there are no guarantees for treatment outcomes. I agree to hold harmless and indemnify the therapist and/or his staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

**Confidentiality**

I understand that confidentiality will be maintained at all times within legal requirements of the State of New York and ethical guidelines according to the Code of Ethics. I understand that confidentiality will NOT be maintained if I threaten or give reason to believe that I will harm myself or others or if child or elder abuse is suspected. If client(s) are involved in couples or family therapy, it is encouraged that each participant maintains a “no secrets” policy and that issues be addressed openly and honestly during the sessions.

**Privacy of Information (HIPAA)**

I acknowledge that I have been given a copy of the therapist’s *Health Insurance Portability and Accountability Act (HIPAA) Patient Notification of Privacy Rights* which describes how records and information about my treatment will be handled.

**Credentials and Supervision**

The Therapist is licensed by the State of New York as an LCSW. If the Therapist is under supervision I understand that they will participate in clinical supervision with other counseling professionals. Cases will be discussed with other counseling professionals solely for the purpose of gaining additional perspective, input and treatment direction. Confidentiality will be maintained in this supervision and the names of clients will not be used. The credentials of the therapist have been explained to me.

**Fees**

I understand the fees involved in this treatment and that payment is expected at the time of the session(s), unless other arrangements have been made. I also understand that failure to pay the expected fee could terminate treatment and the settlement of any unpaid fees will be turned over to a collection agency.

**Cancelation Policy**

I agree to provide 24-hour advanced notice for cancelation of appointments with the exception of a medical emergency or severe weather. I understand that I will be obligated to pay for the missed appointment if I don’t provide advanced notice.

I have read, understand and agree to the above policies and procedures and Statement of Informed Consent:

**Client: Date:**

**Therapist: Date:**