GUIDING PATHS
COUNSELING

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Informed Consent

This document contains important information about my professional services and business policies. Please feel free to ask any questions you may have regarding this document. Once you sign this document, it will become a binding agreement between us.

Qualifications

I am a Licensed Clinical Professional Counselor approved by the Maryland Board of Professional Counselors and Therapists. I am also a National Certified Counselor approved by the National Board of Certified Counselors and a Master Addiction Professional approved by the Association for Addiction Professionals. In addition, I hold a Licensed Clinical Alcohol and Drug Approved Supervisor license that enables me to supervise certain professionals.

Available Services

Guiding Paths Counseling provides substance abuse and mental health services for adolescents, adults over the age of 18, and family members impacted by addiction and mental health issues. These services may include individual, group, family, and couples counseling. In some cases, following an initial assessment, recommendation may be given to pursue treatment through another provider. In this event, you will be provided with referrals and assisted in the process.

Goal

The primary goal of Guiding Paths Counseling is to provide the most effective therapeutic experience available to you. The purpose is to help facilitate behavior change by improving the client's ability to establish and maintain relationships, enhancing the client's effectiveness and ability to cope, promoting the decision-making process, and facilitating client potential and development. Clinicians cannot fix other people's problems. Their job is to provide a safe and supportive environment that allows the individual an opportunity to build the necessary skills needed to make informed and better choices in their life.

Client/Counselor Relationship

You and your clinician have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your clinician can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor are any sort of trade of service for service.

Client Rights

1. You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my approach and methods to you. If I see a child under the age of consent (younger than age 16), all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process and, in turn, may wish to allow confidentiality to be maintained between the child and clinician.

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2. You have the right to decide not to receive therapeutic assistance from me; if you wish, I will provide you with the names of other qualified professionals whose services you might prefer at a cost equal to, or less, than my own usual customary fee.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision without consulting with me.

4. One of the most important rights involves confidentiality: Within limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. Additionally, when more than one family member is being seen in therapy, the clinician views the family as a whole as the client. Therefore, releases of information for family sessions require the written approval of every consenting member of the family who was present at any time during the treatment.

6. Upon your request, any part of your record in the files can be released to any person or agency you designate with a signed consent form. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.

7. You have the right to know about the possible **harmful effects of therapy**. Possible risks of treatment may include, but are not limited to:

- No guarantee as to therapy outcome. Some people experience no improvement in their situation and a few may even believe things are worse after treatment.
- The experiencing of intense and uncomfortable feelings as unpleasant events, relationship patterns, and other concerns are addressed.
- Some health insurance companies will not cover the cost of counseling.
- When using medical insurance for psychotherapy, harmful events include: denial of insurability when applying for medical and disability insurance due to a DSM-V diagnosis (mental illness diagnosis, which are usually required for reimbursement under medical insurance); company (mis)control of information when claims are processed; loss of confidentiality due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about “mental illness,” including driver’s licenses applications, concealed weapons permits, and job applications.

8. Everyone is expected to conduct himself/herself in a responsible manner. A session should not be held when anyone is under the influence of a nonprescription drug, including alcohol. Violence is never acceptable. Either behavior may result in discontinuing a session, or if necessary, calling the proper authorities.

9. Sexual relations between a client and his/her clinician are against the law. Racism, sexism, and other forms of discrimination are not permitted.

The Therapeutic Process and Possible Benefits to Therapy

Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with daily stressors, as well as, family and other interpersonal relationships. Another possible benefit may be a greater understanding of personal and family goals and values. This may lead to a greater maturity and happiness as an individual and

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increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy such as reduced feelings of emotional distress, improved personal performance, reduction of health and safety dangers, and more effective problem solving skills.

In working to achieve these potential benefits, therapy will require that firm efforts be made to change and may involve experiencing significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes. If you experience any of these feelings throughout the therapeutic process, please discuss this with your clinician.

Confidentiality

1. There are certain situations in which a clinician is required by law to disclose information obtained during therapy. Although I am not required to inform you of my actions in this regard, I will make every effort to do so prior to it happening. All communication between you and your clinician will remain strictly confidential except in the following circumstances:
   - You authorize your clinician in writing to disclose information to a third party (i.e. your insurance company for payment)
   - If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authorities
   - When you threaten grave bodily harm to yourself or others. As a clinician, I have a duty to warn those you have threatened and/or to contact law enforcement
   - When a court of law issues a legitimate court order (signed by a judge)

2. Except in the above circumstances, I will release information about you only if you provide a written request. Releases of information for families/couples in therapy require the written permission of every member of the family/couple in treatment who is able to execute a waiver.

3. If I see a child under the age of consent (younger than 16), all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process and, in turn, may wish to allow confidentiality between the child and clinician. If a child's parents are divorced or separated, and have joint legal custody, I will require both parents to sign consent to treat the child even if one parent does not have primary physical custody of the child. If the court has appointed an attorney to represent the child, that attorney has the right to information shared in the session. If stated in a court order, that attorney has the exclusive right to decide if information about the child's sessions will be disclosed or not.

4. There are special confidentiality concerns for families and couples in treatment:
   - I view the couple or family as the "treatment unit." I cannot reveal any individual's confidences to another member of the treatment unit.
   - It is important for you to be aware that "secrets" that are kept from family members are generally not healthy for you or your family. For this reason, if an individual member or subset of the couple/family discloses a confidence that has bearing on other family members, I will encourage the person(s) to reveal the information to the other members. I will support you in finding ways to make such a disclosure.
   - Should you reveal to me a "secret" that you refuse to disclose to the others and that puts me, by my knowing the "secret," in a position of hurting my honest relationship with others in the treatment unit, I will terminate the therapy.

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5. In an effort to provide you with the best services possible and in accordance with state law, I attend a professional supervision/consultation group. The professionals with whom I discuss my cases have access to confidential information and are bound by the same confidentiality measures listed here.

6. In an effort to maintain your confidentiality and maintain **professional boundaries**, I will not acknowledge the existence of the relationship outside of the therapy session unless initiated by the client. The therapeutic relationship is a professional relationship and therefore will not be a social or business relationship at any time. Such a relationship, in my view, would be detrimental to our purposes of therapy.

7. Client records are disposed of seven years after the file has been closed.

Collaborating with Other Professionals

At times it may be important for me to contact other professionals who are helping you or your child. Such professionals include, but are not limited to, teachers, psychiatrists, physicians, probation officers, and attorneys. I will not make such contact without written permission.

In the event of my death or incapacitation, my Professional Executor may take control of records and contact clients.

Fee Schedule

Initial Assessment (45 minutes):	$155	Group Session (45 minutes):	$55/client
Individual Session (30 minutes):	$75		
Individual Session (45 minutes):	$105	Family/Couples Session (45 min):	$105
Individual Session (60 minutes):	$135	Family/Couples Session (60 min):	$135
Individual Session (75 minutes):	$165	Family/Couples Session (75 min):	$165

Sliding scale may be considered in certain circumstances. Please discuss this with your clinician

There may be a charge for other services, including consultation with other professionals, preparation of reports or correspondence, any necessary court appearances, phone calls lasting over 10 minutes, and missed appointments. Clinicians have the right to seek legal recourse to recoup unpaid balances. In pursuing these measures, I will only disclose biographical information and the amount owed, in order to ensure confidentiality.

Financial Agreement

Please understand that you are financially responsible for your treatment and that payment is expected when services are rendered at the end of each session. If payment for services that you receive is not made, the clinician has the right to stop treatment services. Payments made are non-refundable.

Payment can be made through cash, check, and all major credit cards. Checks can be made payable to Guiding Paths Counseling. There is a returned check fee of $35 to cover bank fees.

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Health Insurance Claims

If I do not accept your medical insurance, you can submit forms to your insurance company and may be eligible for reimbursement from them. Since this may require a clinical diagnosis, I will discuss with you what this diagnosis is and what it means so you can make an informed decision before submitting it to your insurance company.

Appointment Issues

If you are late for a session, the time of your session may be shortened, but you will be required to pay for a full session. For individuals who haven't called and are late to an appointment, I will wait for up to 15 minutes and then assume you are not coming. The regular fee will still be expected for the time I reserved for you. If an emergency occurs that causes this, we can discuss that exception.

Cancellation Policy

A 24-hour cancellation notification is necessary for canceling or rescheduling an appointment unless there is an emergency. If 24-hour notification is not given, you will be required to pay the full fee for the missed appointment(s). Insurance companies do not cover the cost of missed appointments; therefore, the client is responsible for the full payment (see fee schedule above).

Legal Proceedings

To contain costs and focus on providing therapy, I do not offer court testimony, provide assessments, nor write qualifying opinions for the court system on behalf of clients. I do not appear voluntarily for legal proceedings. If I am subpoenaed or otherwise compelled to participate in proceedings, the cost of such services is $300 per hour, which includes time for preparation. Additional travel costs may apply if I am travelling more than 20 miles from my practice location.

Communication/Emergency Contact

I am often not immediately available by telephone, email, or texts and during various intervals during the week. When unavailable, you can leave a message at 240-415-8777. This is a confidential voicemail and is monitored frequently. I will make every effort to return your call within 24-48 hours with the exception of weekends and holidays. If you are difficult to reach, please leave a return callback number I can reach you at. Email is to be used for scheduling and administrative purposes only. If you are in need of immediate assistance, please contact 911 or the Frederick County Crisis Hotline at 301-662-2255, or go to your nearest hospital emergency room. If I will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

Termination

Your clinician will discuss the appropriate time to terminate therapy with you. It is important that there be time given before terminating to bring closure to the therapeutic relationship by talking about what has taken place during our time together. If you wish to terminate treatment for any reason, I strongly encourage you to discuss this with your clinician to determine if this is the most feasible course of action for you. If you decide to exercise this right, your clinician can assist you with appropriate referrals and discharge planning.

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Consent to Treatment

My signature below indicates that I, _____, am consenting to take part in the treatment provided by Katie Frazee, of Guiding Paths Counseling, and I have received, agree, and understand the contents of the **Informed Consent Form.**

I understand that no promises have been made to me as to the results of treatment nor of any procedures provided by this clinician.

I am aware that I may stop treatment at any time although I will still be responsible for paying any outstanding balances for services received. I understand that if payment for services I receive is not made, the clinician may stop treatment.

I understand that I am responsible for payment for all therapy sessions at the time of service. I agree to provide 24 hours notice to cancel an appointment. If 24 hours notice is not made, I will be charged full fee for my missed appointment time.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type, cost, dates, and providers of therapy services I receive. I understand that if my insurance company does not make payment for services rendered, I will be responsible for any outstanding balances. If the outstanding balance is not paid, I am aware that my clinician may stop treatment.

I understand that in the event of my clinician's death or incapacitation, the Professional Executor may take control of treatment records and contact me.

I authorize email, text and phone communication unless otherwise agreed upon. I authorize my clinician to leave voicemails on my phone if needed.

My signature also represents that all information has been explained and/or summarized for me by my clinician.

_____ _____
Client Signature Date

_____ _____
Guardian Signature (if applicable) Date

_____ _____
Clinician Signature Date