Www.holisticcounselingpllc.com 1415 S. University Avenue

Phone/Fax: 501-400-8077 Little Rock, Arkansas 72204

**Consent for Release of Information**

**Client Information**

Name  Date of Birth Click or tap to enter a date.

Address 

City  State  Zip Code 

Phone Number 

**Clinic/Health Care Provider**

Who has the information to be released?

Name 

Address 

City State Zip Code 

Phone Number  Fax Number 

**Receiving Party**

Who will the information be released to?

Name  Relationship to Client 

Address 

City  State  Zip Code 

Phone Number Fax Number 

**Information to Be Released**

**What will be released?**

Whether the client is in treatment or not

Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case)

Nature of the project (Services offered, purpose and philosophy of program)

Brief statement regarding progress (client’s denial, client’s understanding of their condition and the

disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules)

Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)

**Purpose of Release**

Why is information being released?

Referral to other services

Coordination of care

Consultation with Doctor

Consultation with other mental health provider

Transfer of care

Other 

**This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:** Click or tap to enter a date.. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

**FOR THE RECIPIENT OF THE INFORMATION:** If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap to enter a date.

Signature of Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap to enter a date.

**CLIENT CONSENT**

**CLIENT/THERAPIST RELATIONSHIP**: You and your Therapist have a professional relationship existing exclusively for Outpatient Behavioral Therapeutic Treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. A gift is not appropriate, nor is any sort of trade of service for payment.

**RISKS AND BENEFITS**: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

**INCAPACITY OR DEATH**: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

**CONFIDENTIALITY:** Follow all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client’s written consent unless mandated by law. ***Possible exceptions to confidentiality include but are not limited to the following situations:*** *child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist’s judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board*. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

**CONSENT TO TREATMENT**: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental

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health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. I also understand my therapist may discontinue services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child’s mental health care and treatment, Holistic Counseling & Consulting will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

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Signature – Client/Parent Date

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Signature – Spouse/Partner/Parent Date

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Signature-Therapist/Degree Date

**FEE SCHEDULE**

**Please read and sign at the end stating you have fully read and understand the information below.**

**CLIENT INTAKE**: Fees for first time clients will be taken in the form of two $142.50 payments if paying with cash. The first is due at the time the appointment is scheduled. For this reason, we ask that you supply a credit card and authorization to process the payment. The second payment will be due when you arrive for your scheduled visit. The total fee for the intake is $285.00.

**APPOINTMENTS**: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, ***for any reason*,** we ask that you call our office ***at least 24 hours in advance***. This will free your appointment time for another client.

**ATTENDANCE:** Regular attendance at scheduled appointments is crucial to effective counseling. Clients who continually do not show up for their visits, without giving proper 24-hour notice, will be responsible for paying fees associated with missed appointments. Missed or improperly canceled appointments will be kept on record. **After 2 *No Show Appointments*, clients will not be allowed to schedule further sessions until after the outstanding balance has been paid in full and will pay the full cost ($225.00) for any missed sessions thereafter. Clients with 3 consecutive *No Show* *Appointments* will be discharged and no longer able to schedule sessions.**

**BALANCES:** Outstanding balances will be subject to a 10% late fee, compounded monthly, for any balance not paid in full or otherwise addressed by your Therapist or the office manager. To avoid

legal aspects of collection procedures and fees, please make all efforts to make your payment.

**Fee Schedule**

**A reasonable fee will be charged for copies of any records requested by client.**

**Diagnostic & Evaluation session & Family Sessions…………. $285.00**

**Individual & Couple Sessions (30-55 min) ……………………. $225.00**

**Outside Office Work (Inpatient, Court, Consulting) …………$225.00**

**Court Appearances (4hr Minimum Retainer) …………………$675.00**

**Written Reports (Insurance Co, Residential) …………………. $150.00**

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**Cancelled/Rescheduled Appointments (24hr Notice) ……………. $225.00**

**No Show Appointments ……………………………………………. $225.00**

**Return Check Fee……………………………………………………. $35.00**

**PAYMENT/INSURANCE FILING: Payment of fees is expected at the time of each appointment. We request that payment be made before your session begins. We will provide a statement for services rendered upon request. No refund will be given if less than 48 hours notices of cancelling court. All fees are to be paid within 30 days if payment plan is offered.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature**

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**Client Signature**