Empowered Wellness Counseling, LLC

Statement of Informed Consent

I (Client(s)(name) agree and give consent for psychotherapy and treatment by Click or tap here to enter text. (Therapist). 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 her staff from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

Confidentiality (initials)
I understand that confidentiality will be maintained at all times within legal requirements of the State of Pennsylvania and ethical guidelines according to the American Counseling Association 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) (initials)
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.

Fees (initials)
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.

Appointments (initials)
The length of sessions is 50 minutes. I understand that appointments should be kept and that I should arrive on time for scheduled appointments. If the client is late for the session, the session time will be cut short based on the allotted time for the session. ***If the client is more than 15 minutes late for a scheduled appointment, the appointment will be considered as "no show" and will need to be rescheduled. "No shows" for appointments are subject to being charged for the session.*** **Cancellations need to be made 24 hours prior to scheduled appointments, except in the case of family emergencies. Cancellations not made within 24 hours are also subject to being charged for the session (except in emergencies).**

Practice Policies (initials)
I have received and read a copy if the Practice Policies and I am in agreement with all information including contact information and emergencies, dual relationships, the EHR system, and the therapy process. I understand that the policies can be revised at any time and updated information will be provided to me. I also know that it is my right to discuss any of these policies with my therapist now or at any time during the therapeutic relationship.

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

Client Date

Therapist Date