FAMILY STRATEGIES COUNSELING CENTER

CLIENT CONSENT

Please READ and SIGN **(Revised 9/29/2017)**

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If I, as your counselor, need to communicate to another about your case, you must give me written permission to do so. The only exception to this is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm, or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide. Insurance companies are entitled to diagnosis, date, and type of service. All therapeutic services via online, phone, VSee or similar medium is provided adhering to the laws of the state of Arizona and the Arizona Board of Behavioral Health; we are licensed within the state of Arizona and assert that services are being provided within the state of Arizona where the therapist resides and is licensed to practice.

INFORMED CONSENT

Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While the therapist will use best effort to assist you, there can be no assurances of results, and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, intervention, and discussion if these seem unclear to you. My signature below indicates that I understand that there are risks for noncompliance with treatment recommendations, and that I will discuss these risks with my therapist.

CLINICAL SUPERVISION

Your therapist _____ is under clinical supervision as an associate licensed counselor with the Arizona Board of Behavioral Health, or is a University intern studying for a Masters Degree, and provides therapy under the clinical supervision of Floyd Godfrey, LPC who is qualified to provide supervision within the state of Arizona according to the laws and regulations set forth by the Arizona Board of Behavioral Health. You can contact him by calling 480-668-8301.

LITIGATION LIMITATION

Due to the nature of the therapeutic process and the fact that this often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce, custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call upon any employee, therapist or staff member associated with Family Strategies & Coaching, LLC, to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

PAYMENT & MISSED APPOINTMENTS

Payment is expected at the time services are rendered, by cash, check or credit. If you are unable to keep an appointment, please notify your counselor as soon as possible. If an appointment is canceled or missed **without 24 hours prior notice, you will be billed at regular session fees.**

FINANCIAL RESPONSIBILITY

The client (or responsible party) is considered responsible for payment of professional services. When you request to bill a third party, such as an insurance company, and that third party fails to make payment within 30 days from the date of billing, payment is expected from client or responsible party with 10 days of receipt of statement. Bills not paid within 30 days from the date of billing will be subject to an interest charge of 10% of the outstanding bill.

INFORMED CONSENT

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form, I acknowledge that I have both read, understood and that I agree to all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me. I also acknowledge that I have received a copy of "Client Rights" and "Complaint/Grievance Procedures."

_____ _____ _____

(Client Signature) (Print Name) Date

_____ _____

(Therapist Signature) Date

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I,_____ am the parent or legal guardian with legal custody of _____ and

(Print Parent/ Guardian Name) (Child Name)

give permission to provide counseling services to my child. _____ _____

(Parent Signature) (Date)