

FAMILY STRATEGIES

COUNSELING CENTER

CLIENT INFORMATION and INFORMED CONSENT

Please read ALL information carefully and thoroughly and initial where indicated.

If you are seeing a therapist at Family Strategies for couples therapy, each person must fill out a SEPARATE set of forms for your first couples session.

WELCOME

It takes courage to seek support, and we look forward to walking with you on your healing journey. These forms outline Family Strategies' professional counseling and psychological services, along with our business policies. Please review this information before your first session. If you have any questions, we are happy to discuss them with you. You will be asked to provide your initials and signature in several places throughout the forms.

THERAPY SERVICES - RISKS and BENEFITS

_____(initial) Whether working with a licensed counselor or a licensed psychologist, therapy is designed to help you address emotional and personal challenges. The process often involves discussing difficult parts of your life, which may bring up uncomfortable feelings such as sadness, guilt, shame, anger, or frustration. At times, the insights you gain and the choices you make in therapy may affect important relationships—some may improve while others may change or even end. Your therapeutic journey can also lead to greater self-awareness and healthier connections. If you ever have concerns about your therapy experience, please bring them up with your therapist so you can work together to address them as you move forward.

THERAPEUTIC APPROACH and STYLE

_____(initial) At Family Strategies, our goal is to help you navigate life and relationship challenges in a safe space where you can heal, gain insight, and practice healthy coping tools. Our licensed counselors and psychologists provide a collaborative, honest, and empathetic therapeutic process that also offers structure, challenge, and clear boundaries. Using client-centered approaches, your therapist will reflect, guide, and point out patterns that may be holding you back. Together, you will create a treatment plan based on your needs, concerns, and goals. We believe every client has the capacity for healing and growth, and that each individual is responsible for their choices and progress. *While we cannot guarantee outcomes, we are committed to supporting your journey toward meaningful change.*

DESCRIPTION OF THERAPY PROCESS

_____(initial) Therapy is a collaborative process between you and your licensed counselor or psychologist. Its purpose is to promote growth, insight, and positive change. At times the process may feel challenging, while at other times it may feel encouraging or rewarding. You are expected to take an active role in your treatment, including any suggested activities outside of sessions. You always have the right to ask questions, refuse recommendations, or request changes to any service or intervention. Together, you and your therapist will create a treatment plan based on your needs and goals. If you have questions about the length or direction of treatment, you are encouraged to discuss them at any time. While your therapist will provide support, guidance, structure, and clear boundaries, no specific results can be guaranteed. At Family Strategies, we believe every client has the capacity for healing and growth, and we are committed to supporting you in that process.

APPOINTMENTS and CANCELLATIONS

_____(initial) Cancellations made less than 24 hours before a scheduled session will be charged the full session fee. If you do not attend a scheduled appointment and have not canceled at least 24 hours in advance, you will also be charged the full fee. You are responsible for keeping track of your scheduled sessions. *If you are sick or experiencing symptoms of illness, please call before your appointment to request a phone or video session. If your counselor or psychologist is ill, the same option will be extended to you.*

CLIENT INFORMATION and INFORMED CONSENT

THERAPIST AVAILABILITY BETWEEN SESSIONS

_____(initial) Your therapist may be available to answer a short email regarding your therapy appointment times or therapy homework no more than twice per month without charging a fee. We will not process therapy issues via email unless you have been specifically instructed to do so as part of your treatment. If therapeutic services are required during non-business hours you will be charged 25% of your therapist's rate for every 15 minutes.

LENGTH of THERAPY

_____(initial) Therapy is a process that is unique to each client and the challenges they are experiencing. Some issues can be worked on very effectively in a short period of time, and other challenges may take much longer. It can be difficult to predict exactly how long therapy will last so this is best discussed in your first session. You and your therapist will put together a treatment plan and goals that you will be working toward. If you have questions regarding the length of treatment, please feel free to discuss this with your therapist at the start and/or at any point during therapy

TERMINATION of THERAPY

_____(initial) You may terminate therapy at any time. When ending therapy, we request at least one final session to review your progress and closure. Some clients later choose to return for additional support. If you decide to return, please know we welcome that possibility; however, re-engagement is at the therapist's discretion and subject to availability. There may be a 2–4 week wait. If your therapist is unavailable, we can place you on a waitlist or provide referrals to another qualified provider. Your treatment records are confidential and will be securely maintained for six (6) years following your last session. You may request a copy of your records at any time by submitting a written request directly to your therapist at our office.

CLINICAL SUPERVISION (where applicable)

_____(initial) If your therapist is an associate licensed counselor under the Arizona Board of Behavioral Health Examiners, or a university intern completing graduate training, all services provided by them are under the clinical supervision of Dr. Kim Buck, LPC; John Hinson, LPC; Abbie Ashton, LMFT; Angie Hatch, LPC; John McLean, LPC; Nick Miller, LPC; and/or Julie Young, LPC—each qualified to supervise according to Arizona law. Supervisors may be contacted at 480-668-8301.

PHYSICAL CONTACT

_____(initial) Sexual contact is never acceptable in the therapeutic relationship. In some cultures, a supportive hug or other physical contact can be an expression of affection, or a greeting, or a goodbye. However, supportive physical contact can also be misconstrued, triggering, or may interfere with the therapeutic relationship. As a general policy our therapists do not offer supportive physical contact of any kind within the therapeutic relationship. Please understand, this is not an expression of judgment, dislike or dismissal, rather it is in the best interest of your clinical care based on a professional and therapeutic boundary. You always have the right to refuse physical contact at any time or for any reason.

SOBRIETY POLICY

_____(initial) Family Strategies asks that all clients, couples, families, and group members arrive at therapy sober and not under the influence of drugs and/or alcohol. If any member of our staff notices that you are intoxicated or substance impaired, the therapy session will be immediately terminated. Once you are safely home, you may reschedule the therapy session. You will be charged your full fee for the session if you arrive intoxicated or impaired.

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E-THERAPY - i.e. TELEMEDICINE, TELETHERAPY, CYBERTHERAPY, VIDEO CONFERENCE (when applicable)

E-therapy uses electronic communication (video, phone, or other technologies) to provide mental health services across locations. While convenient, it has risks, including limits to confidentiality and possible technology failures. In case of an emergency and your therapist is unavailable, you should call 9-1-1 or go to your nearest emergency room. If video is not available, your licensed counselor or licensed psychologist will ask you to verify your identity. You will also be asked to provide your physical location at the start of each session and confirm that your setting allows for confidentiality. Family Strategies does not permit counselors, psychologists, or clients to record any portion of video or phone sessions unless written consent has been obtained beforehand for training or supervision purposes.

By signing below, you acknowledge these terms, including the emergency protocol, identity and location verification, and confidentiality requirements for e-therapy.

Client's Signature ***Signature of Client or Legal Guardian if client is under the age of 18*** ***Date***

RELEASE of INFORMATION (ROI) CONSENT

In an effort to provide me with the best possible care, I authorize my licensed counselor or licensed psychologist to share confidential information about my treatment with professional clinical staff at Family Strategies for purposes of training, therapeutic benefit, and coordination of care. Professional staff may include the executive team, supervisors, therapists, and interns with relevant expertise in clinical issues and treatment planning. If it would be helpful for these professionals to participate directly in my treatment or attend a session, I will provide verbal consent at that time. I give this authorization voluntarily and have discussed any questions with my therapist.

I authorize my licensed counselor or licensed psychologist at Family Strategies, LLC, to share confidential information about my treatment with other professional clinical staff as needed for my care. This may include executive directors, clinical supervisors, and other therapists or psychologists who provide expertise in clinical issues and treatment planning. I give this authorization voluntarily and have discussed any questions with my therapist. By signing, I acknowledge that I have read, understood, and agree to the terms of this release. I also understand that my records are protected under federal and state confidentiality laws and regulations.

Client's Signature ***Signature of Client or Legal Guardian if client is under the age of 18*** ***Date***

DUAL THERAPY

_____(initial) It is unhelpful for two different therapists to provide counseling for the same client at the same time. Unless there is a compelling clinical reason, a crisis, or a specialized therapy treatment plan that we will be working on, we do not work with clients who are under the care of another therapist outside of Family Strategies. If you are working with another therapist outside our office, please disclose this so that you can discuss the next steps with your Family Strategies therapist. If your therapist has referred you to Family Strategies for specialized treatment (i.e. sex addiction, sex therapy, etc.), we will need to have a release on file from you in order to coordinate care with your primary therapist and collaborate on a clinical plan that best supports your process.

CLIENT INFORMATION and INFORMED CONSENT

CONJOINT SESSIONS

_____(initial) On occasion, and only when it supports your therapeutic goals, your therapist may invite you to include a family member or significant other in a session. This is at your therapist's clinical discretion and is not a substitute for couple's or individual therapy for the guest. If a significant other attends, the purpose is solely to support your work or serve as a check-in, not to establish ongoing therapy for them.

NO SECRETS POLICY

_____(initial) Please note that with couples therapy the couple is considered the client (i.e., the treatment unit), not the individual. We follow a "no secrets" policy in marital/couples therapy. This means confidentiality does not apply between partners if one member shares information privately with the therapist that is harmful, betraying, or damaging to the other (e.g., affairs, financial betrayal). Personal thoughts, feelings, and desires are not considered secrets in this context. At times, an individual session may be scheduled to support the couple's overall progress, but only with mutual agreement. Information shared in such sessions will generally not be kept confidential from the other partner. The therapist will encourage disclosure of any significant secret in the next session and will provide support in that process. The therapist also reserves the right to disclose information shared in an individual session if necessary to support the couple's treatment goals.

GROUP THERAPY

_____(initial) Due to the nature of group therapy, Family Strategies and its licensed counselors/psychologists cannot release group records without breaching the confidentiality of other participants, which is prohibited by Arizona law. Because group notes are kept on a single form, individual records are not available for copy or release. If you require group records for legal purposes, you (or your health care decision maker) must submit a written request. In such cases, Family Strategies may only provide dates of service and general topics covered in classes or group sessions.

COURT REPORTS or LETTERS, COURT HEARINGS

The therapists at Family Strategies do not write legal letters or court reports on behalf of clients involving divorce, custody or other legal matters or lawsuits. We do not write letters pertaining to legal matters to any outside person (i.e. doctor, school, attorney, etc.) or agency regarding your treatment. If a special circumstance arrives where a letter is required by court order, it will require your written consent and will be billed to you at \$25.00 per page and in addition to your therapist's hourly fee.

As a general policy the therapists at Family Strategies are not forensic specialists and prefer to not testify or participate in court proceedings on behalf of a client as that has the potential of changing the overall purpose and scope of our services. If you become involved in legal proceedings that require mandated participation by your therapist, you will be expected to pay for all of your therapist's professional time including preparation and transportation time and costs, even if called to testify by another party regarding your case. Because of the time involved and the interruption to your therapist's clinical work and compensation, you will be charged \$350.00 per hour for preparation, travel, and attendance at any legal proceeding on your behalf. A detailed accounting of time is available to you upon request.

Court fees can be very expensive. Please sign and date below to indicate that you understand your financial responsibility in covering these expenses should we be mandated to go to court for a legal issue you are involved in. Your therapist is not a court advocate or friend. A therapist must legally speak truthfully under oath.

Client's Signature Signature of Client or Legal Guardian if client is under the age of 18 Date

CLIENT INFORMATION and INFORMED CONSENT

CONFIDENTIALITY

Therapy is most effective in an atmosphere of trust. All services provided by licensed counselors and licensed psychologists are strictly confidential and will not be disclosed without your written consent, except as required by law (see exceptions in following section). If you wish your therapist to communicate with another professional or individual (e.g., physician, former therapist, teacher, or family member), you must provide signed written authorization, and your therapist will determine whether such communication supports your therapeutic process. At times, consultation with other clinicians may be used to enhance your care. As part of the Family Strategies team, your therapist may draw upon the collective expertise of our clinicians to provide you with the best possible treatment.

By signing, I acknowledge that I have read, understood, and agreed to this release. I understand my records are protected under Federal and State Confidentiality Regulations. I may revoke this consent at any time through written notice. I also understand that my participation in Family Strategies' treatment program(s) is conditional on this consent.

Client's Signature Signature of Client or Legal Guardian if client is under the age of 18 Date

LEGAL EXCEPTIONS to CONFIDENTIALITY

Your information is kept confidential except in situations involving child abuse, suspected child abuse, elder abuse, dependent adult abuse, intent to harm yourself or others, or when disclosure is required by law (such as a court order). By law, all licensed counselors and psychologists are mandated reporters. This means that if you are suicidal or homicidal, your therapist at Family Strategies will take all reasonable steps to prevent harm. A minor is legally defined as anyone under 18 years of age. Regardless of whether your therapist works with minors, all Family Strategies therapists and staff are mandated reporters of abuse, neglect, or illegal sexual activity involving minors. Any such information must be reported to the appropriate authorities.

I understand the limits of confidentiality and the mandated reporting responsibilities of my therapist and Family Strategies.

Client's Signature Signature of Client or Legal Guardian if client is under the age of 18 Date

THERAPY SESSIONS and FEES

_____(initial) The fee for a standard therapy session at Family Strategies varies by therapist. The standard therapy session is 45 - 55 minutes in length. Therapy can be conducted in person in the office, via phone, or videoconference. It is understandable that occasionally you may be late. If you are late to your session, please understand that the session will not extend past your allotted time, nor will the time be made up at future sessions. Therapy sessions are paid via credit card, check, or cash. Please fill out the credit card form included in this packet and bring with you to your first session. If paying with cash, please bring the exact cash amount for your session fee as Family Strategies does not normally keep cash on premises.

Fees are reviewed annually and may increase periodically. The increase will be discussed with the client, and a 30-day notice will be posted prior to the increase. Your therapist is happy to answer any questions you may have about this fee agreement. Please understand that you have the right to terminate therapy at any point. If you have any questions regarding the fee policy, please do not sign until discussing with your therapist

CLIENT INFORMATION and INFORMED CONSENT

FINANCIAL RESPONSIBILITY

_____(initial) You (or responsible party) are 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, the client or responsible party is expected to pay within 10 days of receipt of the 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.

BILLING as a FACILITY and PROVIDER

_____(initial) Family Strategies Counseling Center is licensed with the Department of Health Services, Medical Licensing Division. Similar to a hospital, we bill insurance for both facility and provider costs, which may result in two Explanation of Benefits (EOBs). One EOB may show provider services under the name of a licensed supervisor from our agency. This happens because our “board” of supervisors—made up of licensed counselors and licensed psychologists—oversees the clinical work of all therapists. Clients, however, are only responsible for copays and deductibles tied to facility fees for the services actually received.

INSURANCE BILLING

_____(initial) Family Strategies accepts select in-network insurance plans and can bill them on your behalf. Clients are responsible for knowing their insurance benefits and coverage.

As a DHS-licensed facility (Medical Licensing Division), we bill insurance for both **facility** and **provider** fees, similar to a hospital. This may result in **multiple Explanation of Benefits (EOBs)**. You might see:

- An EOB listing a **supervisor’s name** — this is normal. Our clinical supervisors oversee all therapists, and any of their names may appear.
- An EOB for **provider fees** — however, **you are only responsible for the copay or deductible assigned to the facility fees**.

If your insurance is **out-of-network**, you may download a statement from our patient portal and submit it to your insurance for reimbursement.

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**” as well as the “**Notice of Privacy Policies – HIPAA**” documents.

Client Signature Signature of Client or Legal Guardian if client is under the age of 18 Date

Printed Name of Client

Therapist Signature Date

CLIENT INFORMATION and INFORMED CONSENT

CONSENT FOR TREATMENT OF MINORS UNDER THE AGE OF 18

I, _____ (*print name of legal guardian*) am the parent or legal guardian with

legal custody of _____ (*print name of client*) **and** give permission to

FAMILY STRATEGIES COUNSELING CENTER to provide counseling services for my child.

NOTE: If parents are divorced, and the above parent has full legal custody, court custody documents must be provided prior to the first session. If parents share joint custody, both parents MUST SIGN the "Client Consent" form.

Signature of Parent(s)/Legal Guardian(s)

Date