Susan Strong

MED in Counseling
AZ Licensed Professional Counselor
AZ Licensed Independent Substance Abuse Counselor

Informed Consent

Welcome to my practice. I am committed to working with you and/or your family to achieve your goals for our time together. A counseling situation offers a unique relationship between myself and you or your family. I have put together this document to ensure that there are no misunderstandings about the various aspects of the counseling and psychotherapy services.

Financial: Payment is expected at the time of your appointment. To maximize your therapy hour, have your check written out before your session. I accept cash or checks but not debit or credit cards. You can receive a statement at the end of each month or session as you wish.

Insurance: I do accept some insurance plans. If you have a health insurance policy other than the ones I accept but your health insurance policy covers "out of network" providers, you may submit the super bill and recover whatever percentage they pay. There is usually an upfront "out of network" deductible. I will be happy to help you with this process.

Appointments: I usually reserve an hour for each appointment with you. If you should need to cancel an appointment, I will need **24 hours** notice and will not hold you financially responsible for the session. If you cancel less than 24 hours before your session, we can try and reschedule during the same week. If that is not possible due to my schedule or yours, **you may be billed for the full amount of the session missed**. I will make every attempt to reschedule. Please note that if your sessions are on Friday, this will be more difficult. Should I, for some reason not be available to you at your scheduled time and have not given you notice, I will offer you a session free of charge. Our time is equally valuable.

Confidentiality: All communications between us are held in the strictest confidence. Ordinarily, the only way information will be released is with your written consent. There are exceptions that can occur: when there is real or potential life or death emergency, when the court issues a subpoena, or when child/elder abuse or neglect is involved. For more information, please see the Notice of Privacy Practices.

Confidentiality and the Family: I will keep individual information confidential; however, I will encourage the family members to communicate openly with each other in the course of treatment. When working with children under 18, I will need parental consent. My family ethic is for all to communicate together. Therefore, even if the patient is a child we will meet as a family frequently to discuss family matters in openness. If you have been referred by your family physician, a signed release will be necessary to discuss matters about the reason for the referral.

Risk of Treatment: Psychotherapy, like most endeavors in the helping professions, is not an exact science. There are no guarantees that the treatment provided will be effective or useful. Moreover, the process of individual counseling usually involves working through tough personal issues that can result in some emotional or psychological pain. In the case of marriage and family counseling, interpersonal conflict can increase in the process of therapy. The potential for a divorce is always a risk in marital counseling.

Methods of Therapy: My specialty is in trauma resolution and treatment. While my primary method of therapy is Cognitive Behavioral Therapy (CBT), I also have been trained in alternative types of therapy such as Eye Movement Desensitization and Reprocessing (EMDR), Guided Imagery, and Mindfulness Meditation. I am also able to provide therapy from a Biblical perspective if you are interested in faith-based therapy.

If you are comfortable with ALL of the techniques listed above, please initial here _____.
If you wish to ONLY participate in more conventional talk therapy, please initial here _____.
If you would like to include faith-based, non-denominational, Christian therapy, please initial here _____.
If you are NOT comfortable with any specific therapeutic techniques, please indicate which techniques:
_____.

Consent for Evaluation and Treatment: Consent is hereby given for evaluation and treatment under the terms described in this consent document. It is agreed that either of us may discontinue the treatment at any time and that you are free to accept or reject the treatment provided.

Client Signature: _____ Date: _____

Consent for Treatment of Minor Children

Date: _____

Parent/Guardian's Name: _____
Parent/Guardian's Signature: _____

Relationship to Child: _____

Legal Guardian: _____

Child's Name: _____ Age: _____

Child's Name: _____ Age: _____

Child's Name: _____ Age: _____