Attachment Center LLC
(d/b/a Fractured Hearts Counseling)
18890 Rd 89, Cecil Ohio 45821 Phone:260-667-3807

Client Information and Acknowledgment of Informed Consent to Treatment

I am independently licensed as a LPCC-S engaged in private practice proving mental health services through Attachment Center, LLC.

Please read through the following informed consent agreement. What follows is a basic understanding between client and therapist. In general, what are listed below are the responsibilities and obligations of your therapist, and also some expectations of you as the client. This document also contains important information about our professional services and business policies. Do not sign the informed consent unless you completely understand and agree to all aspects. If you have any questions, please let me know at your first session. When you sign this document, it will represent an agreement between us.

Voluntary Participation: All clients voluntarily agree to treatment, and accordingly may terminate any time without penalty. Counseling involves a large commitment of time, money, and energy, so you should be thoughtful about the therapist you select. In the first couple of sessions, you should be deciding whether your therapist is right for you. If you feel it is not a good match, then your therapist will be happy to assist you in finding a new therapist.

Risk and Benefits of Therapy: Therapy may not at first feel like it is helping and may at times make thing more difficult as you apply new approaches to your life situations. You might experience uncomfortable feelings, like sadness, anger, frustration, loneliness and helplessness. On the positive side counseling can lead to better relationships, solution to problems and reduction in negative feelings. There are no guarantees in what you will experience.

Client Involvement: The client is expected to show up for treatment prepared to focus on and discuss therapy goals and issues and not attend under the influence of mood-altering chemicals. The more honest you are with yourself and your therapist the more success you will have in treatment.

Therapist Involvement: I will be prepared at the designated time of your appointment, unless an unforeseen circumstance prevents me from doing so. I will be attentive and supportive in you reaching your therapy goals. I will use a variety of techniques that have been shown to be effective for the symptoms and situations you are experiencing.

Credentials and Qualifications: I have a Masters of Arts Degree from Cincinnati Christian University and am a Licensed Professional Clinical Counselor with the state of Ohio.

Counseling Approach and Therapy: I generally use therapy approaches that includes Cognitive Behavioral, affect regulation, human development principles, attachment-based practices, best practice techniques along with Christian valued practices in treatment.

Colleague Consultation: In keeping with standard of good care I will at time seek consultation form other mental health professionals to help provide you the best care possible. I will maintain complete confidentiality and protect your identity by not using real names or any identifying information.

Appointments: You can schedule or cancel an appointment at 260-667-3807. Appointments will be scheduled at 50-60 minute increments. Your fee for the session is $125. Appointments typically would be scheduled weekly unless preferred by the client or therapist. The number of appointments and the amount of time it takes to recover from a particular event is different for each person therefore an exact duration of treatment is not possible to estimate. Also, if you are using your insurance benefits some insurers may limit the number of sessions that you will be allowed to receive under their plan.

Confidentiality: Laws protect the privacy of all communications between client and a therapist. In most situations I can only release information about your treatment to others if you sign a written authorization. There are some situations which I am legally obligated to take actions that I believe are necessary to attempt to protect others from harm and in such cases I might have to reveal some information about your treatment. If a situation arises, I will make every effort to discuss it with you before taking any action. The following are required by law to report:

- If I have reason to believe that child or vulnerable adult is being neglected or abused, I am required by law to report it to appropriate state and local agency.
- If I believe you're presenting a clear and substantial danger to harm to yourself or others I may be obligated to take certain protective actions. This may include contacting family members, seeking hospitalization for you, notifying the potential victim(s) and notifying the police.
- If I am court ordered to release copies of records.

Professional Records: The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problems affect your life, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, results of clinical tests (including raw test data), any past treatment records that I receive from other providers, reports of any professional consultations, any payment records, and copies of any reports that have been sent to anyone. You may examine and/or receive a copy of your Clinical Record if you request it in writing. If the law allows it, and if I determine that for clearly stated treatment reasons that disclosure of the records to you is likely to have an adverse effect on you, I may exercise the option of turning the records over to another mental health therapist designated by you. Because these are professional records they can be misinterpreted and/or upsetting to untrained readers, I therefore recommend that you initially review them with me, or have them

forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge fees set under Ohio and federal laws for copying and sending records. These fees may change every year, so I will let you know what the charge is at the time that a records request is made. As your therapist, I may also keep a set of psychotherapy notes which are for my own use and are designed to assist me in providing you with the best treatment. These notes are kept separate from your Clinical Record. They are not routinely released to others with your Clinical Record, except in rare legal circumstances. Their release requires a separate authorization in addition to one for the Clinical Record. I will discuss with you whether or not I am maintaining psychotherapy notes on you.

Fees, Payment and Billing: Payment for services is an important part of any professional relationship. This is even more true in therapy; one treatment goal is to make relationships and the duties and obligations they involve clear. You are responsible for seeing that my services are paid for. Meeting this responsibility shows your commitment. Payment methods include check, cash, credit card, or debit card. My billing and contract negations with insurance companies is managed through Headway so your bill may reflect different rates of charge.
My current regular fees are as follows: $125 per 50-60 minute session.

Minors: If you are under 18 years of age, please be aware that the law generally provides your parents the right to examine your treatment records, unless blocked by court order. Before giving parents any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have. In addition, if one parent brings in a child and the therapy only involve the child, under Ohio law generally both parents have access to the child's records and anything the other parent says in the sessions, unless that access is blocked by a court order. Legal documents need to be provided in cases where custody, visitation, shared parenting, guardianship or other matters which are covered by court documents are involved before I see a minor for treatment. I also retain the right under Ohio law to provide client records to another therapist if I believe the release of the records could have an adverse effect on the client. Minors 14 years of age and older should be aware that they have an option to see me on a limited basis without their parents' knowledge, except where there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of my intent to inform the minor's parent, or guardian. Only the minor is responsible for paying for services under this option.

Emergencies and After-Hours Care: I may be reached at 260-667-3807. I will make every effort to return messages within 24 hours; however, I may not always be able to do that. Current clients will be notified during sessions of upcoming travel or vacation. If you have an emergency, you should go directly to a hospital emergency department, call 911. Emergencies are urgent situations and require your immediate action.

Incapacity or Death of Therapist: In the event that I am incapacitated or die, it will be necessary for another therapist to take possession of your file and records. By signing this form, you consent to allow another licensed mental health professional whom I designate to

take possession of your file and records, provide you with copies upon request, or to deliver them to a therapist of your choice. In signing this form below you agree that if you select a successor therapist that you will notify the licensed mental health professional designated by me to maintain your records of that choice.

Email and Texting: I will use texting to schedule appointments and notify you if I need to cancel an appointment. I will not use texting or email to discuss relevant treatment issues or help you manage a crisis situation. If you decide you want to utilize any form of electronic communication, you acknowledge that there are confidentiality risks inherent in such communications if they are unencrypted and you agree to accept those risks. If you wish to use unencrypted electronic communications, please place your initials in the space below: _____ (By initialing this section you agree that you understand the risks involved in unencrypted electronic communications and agree to accept such risks in communications from either me to you or you to me that involve scheduling and/or therapy).

Acknowledgment of Informed Consent to Treatment: I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize you to provide such care, treatment or services as are considered necessary and advisable, and to make all payments described herein. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through you at any time. I also understand that there are no guarantees that treatment will be successful. By signing this Acknowledgment of Informed Consent to Treatment, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and I agree to be bound by the provisions in this agreement. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. If a minor is the client, I am signing on behalf of the minor as the authorized parent/guardian. (Information on Minor rights will be shared with the minor) I also acknowledge receipt of the Attachment Center LLC ‘s Notice of Privacy Practices.

Client Name(s) (please print): _____

Client(s) Signature:_____ Date _____

Parent(s) or Guardian Signature (for minor child or children or disabled adults):

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