INFORMED CONSENT

Welcome! I want you to know that I look forward to getting to know you and working with you as we begin our therapeutic work together. This document contains important information regarding my policies and processes. These are important things for you to be aware of as we work together. You are invited to ask me any question you have about these policies or about the counseling process.

Today's appointment will take approximately 50-90 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. The market rate for a 50 minute session for me is $75. By signing this form, you are agreeing this rate is what you will pay unless you make arrangements with me prior to counseling. I do work on a sliding fee scale so we can discuss what you are able to pay for sessions.

In addition to provided face-to-face, Jeremy is able to provide counseling via internet, using to residents of Ohio If this is the format you, and I agree to, you understand that though online counseling is HIPAA compliant that because of the nature of the internet it is not the same as a session in person. Jeremy is a Board Certified TeleMental Health (BC-TMH) Provider.

Phone calls are not to be considered confidential due to cell phone reception and the technology. Though you may text necessary updates pertaining to making or cancelling a session please note this is not HIPAA compliant. By using phone or text messaging you are acknowledging the risk of using such technology.

Jeremy's license number as a professional counselor is, C 1200119. You may verify the status of the license at www.csmft.ohio.gov. This information is required by the Counselor, Social Worker, and Marriage and Family Therapist Board, which regulates the practices of professional counseling, social work, and marriage and family therapy in this state. You may contact the state CSWMFT Board with complaints or concerns: Counselor, Social Worker and Marriage & Family Therapist Board 77 South High Street, 24th Floor, Room 2468, Columbus, Ohio 43215-6171; (614) 466-0912. I am supervised by Barb King, LPCC-S and you may reach her

About Jeremy:

Jeremy Spence LPC has earned a Bachelor of Arts Degree in Bible from Cedarville University and has completed his Master of Science in Mental Health Counseling from Capella University. He has over 15 years experience working with adolescents, their families, and other individuals in a faith based environment. Jeremy practices standard client directed and cognitive therapy (reality therapy) for most conditions. Jeremy does not impose any religious values on his clients and integration occurs at client request. Treatment practices, philosophy and plan limitations and risks will be discussed with you today. Along with the above experiences and information Jeremy is able to conduct counseling through technology as he has obtained extra credentialing

and competency on how best to use technology to serve clients.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information you and/or you child or children report about physical or sexual abuse or neglect; then, by Ohio State Law, I am obligated to report this to the applicable Child Protection agency, b) where you sign a release of information to have specific information shared, and c) if you provide information that informs me that you are in danger of harming yourself or others d) information necessary for case supervision or consultation and e) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. I will follow those emergency services with standard counseling and support to the client or the client's family. There may be times when supervision is obtained, help with a case and if a diagnosis is necessary or beneficial, but then only necessary information will be shared with the supervisor.

No Secrets Policy:
Please note that with couples and family therapy the couple and/or the family is the client, not the individuals. As a result, I practice a **"no secrets"** policy when conducting marital/couples/family therapy. This means that confidentiality does not apply between the couple or among family members when one member of the treatment unit requests an individual session or contacts me outside of the therapy session to share a secret. When in couples or family treatment, an individual session may be scheduled on occasion to assist in the overall treatment and when mutually agreed upon. **Please understand that any information given in the individual sessions will not be held in secret in couples or family therapy.** I will encourage the person holding the secret to share the secret in the following session(s) and will support the client in doing so. And I also reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as I deem appropriate or necessary to support the treatment unit's overall treatment progress and goals. If you are seeking couples or family therapy, each member of the treatment unit needs to read and sign this agreement.

Contact Between sessions:
I am available to take a brief 10 minute phone call or answer a short email regarding your therapy appointment times or therapy homework 1 time between therapy sessions, and no more than one time per month without the client incurring a fee. If the client feels that more contact is needed between sessions I am willing to discuss the possibility of increasing the weekly sessions or scheduling a paid phone appointment temporarily if I feel that it supports the client's therapy. If frequent non-crisis contact continues between sessions, it will be important to talk about referring out for a higher level of care than once a week therapy can provide.

I also make it a policy to **not** have clients as social media “friends”. Please know the request will be denied.

Emergency contact:
For emergency only situations, I will make every effort to return the call or email within 24 hours. I ask that if the client is facing a life threatening emergency that they call 911 immediately. There will be a regular session fee for emergency phone calls and sessions that are in excess of 10 minutes, or more than 1 time per month. I reserve the right to not charge at my discretion.

Fee Schedule:
Below is the market rate for my services. I can work on a sliding fee scale with the listed amounts being the starting point for decisions made. No one will be turned away due to inability to pay the stated fees. Please discuss any issues you have with these fees with me prior to treatment

Initial meeting (60-90 Minutes): $125; 50 Minute session: $75; Group Sessions (90-120 minutes) $40-50 per session; Report Preparation: $100 per hour; Court depositions and/or court appearances: $125 per hour.

Informed Consent Signature Page

Signature(s)_____Date_____

Signature(s)_____Date_____

Emergency Contact Information
In the event of an emergency, please provide a contact:
Name _____
Relationship_____
Phone _____ Alternate Phone _____

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year.* ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no information will be shared.*

___You may inform my physician ___I decline to inform my physician

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

Signature(s)_____Date_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that _____ maybe treated as a client by Jeremy Spence LPC understand that privacy and confidentiality is important to keep with your adolescent because it will facilitate counseling. I ask that you respect the privacy and confidentiality. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.*

Signature(s)_____Date_____

Signature_____Date_____

Adolescent Consent Information

I understand that confidentiality is the foundation of the counseling relationship and that my counselor will keep information confidential unless one of the criteria mentioned above is met. However, I also realize that my counselor may request that I disclose information to my parents that may help my relationship with them.

I also understand that information will not be shared with my school and teachers, even that I am seeing a counselor, unless I or my parents/guardian give permission for this information to be shared. I am able to disclose this information because confidentiality is something I am allowed to break.

If your parents want information that you may not want them to know we will discuss this during the session in order to help resolve the best course of action. I realize that a text message to my counselor is not confidential or private and will refrain from doing so in order to protect my privacy.

Adolescent Signature _____ Date_____