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CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and I have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Physical contact is very minimal, occurring primarily through hand shaking, a hug if a client requests it, and tapping on acupuncture points if we are practicing EMDR, EFT, or Bodytalk therapy. Bartering for services can be discussed in cases of extreme financial hardship, but is not customary practice in the counseling field.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. I cannot guarantee these benefits, however it is my desire to work with you to attain your personal goals for counseling. If you or I deem it necessary, a referral to a different therapist is always open for discussion. I reserve the right to refer, if I feel like we are not a good fit, I am not qualified in the area you need help with or generally think you are not getting the type of help you need with me. Termination of therapy may look different for each client. Some end of therapy sessions will be a thorough reflection on the client's time in therapy, others may end with referral to a different therapist, and others may end therapy by not scheduling another appointment. It is preferred by the therapist that client and therapist have one final session to process their time together, things learned and tools client may have gained for the future.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. I will make every attempt to schedule you as soon as possible or to offer other options. I will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours and/or you need immediate attention, please call 911 or have someone take you to the nearest emergency room for help. Phone calls are returned within one business day. Please note that my office hours are Monday through Friday from 10am-6pm. All clients will be notified if/when I am out of the area.

CONFIDENTIALITY: I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you. Please refer to the Notice of Privacy Practice. If you agree to email and or text

exchanges on the PDS, please do so with the understanding that both of these forms of communication are not private and confidentiality could possibly be compromised Discussions between a Therapist and a client are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; suits in which the mental health of a party is in issue; situations where the I have a duty to disclose, or where, in my judgment, it is necessary to warn or disclose; any fee disputes regarding treatment; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing board. By signing this Information and Consent Form, you are giving consent for me to share confidential information with all persons mandated by law, as well as the insurance carrier responsible for providing your counseling treatment and payment for those services, and you are also releasing and holding harmless Michele Freeman from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If Michele Freeman believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to her to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to Michele Freeman contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name Telephone Number

_____

_____

_____

CONSENT TO TREATMENT:

By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time.

_____ _____

Signature – Client/Parent Date

_____ _____

Signature- Therapist Michele M. Freeman MS NCC LPC Date