The Heart Centered Life, LLC

Treatment Informed Consent

Name: _____ Date: _____

Date of Birth: _____

Purpose of treatment: To support the client (you) in transformation and accomplishment of goals.

General procedures used in treatment: Experiential, cognitive behavioral, and spiritual.

Procedure's benefits, limitations, and risks: Benefits include improved functioning in social, vocational, educational, and/or relational areas. Limitations are those of any counseling, including the skills of the counselor and the capabilities and potentials of the client. Risks include disturbance of emotional and functional aspects of your life.

Please put your **initials** in the blanks to acknowledge having received copies of, and having read, the following policies (see attached policies):

____ Confidentiality

____ Financial Policy

____Skype/Video/Phone Policy

____ Credentials

____ Treatment Decisions

____ Emergencies

____ Client/Counselor Relationship

I have read the above referenced policies (and attachments) and I both understand and agree to comply with them as described. I understand that I can rescind my authorization at any time by notifying Arianna Gray, LPC in writing. I hereby give my Informed Consent to treatment.

_____ _____

Signature of Client or Guardian Date

_____ Initial here if Addendum for Treatment of a Minor is Attached

For office use only: verification that client/guardian has read and understands informed consent document

_____ _____

Counselor Verification Date

Arianna Gray, LPC (LPC-14426 (AZ))

Confidentiality

I respect the confidentiality of what you will tell me and what I may learn about you. The confidentiality of the client records I keep are protected by Federal law and regulations. Generally, this means that I will not reveal to anyone that you are in treatment, or disclose any information identifying you as having a mental health problem unless:

1) You consent to the disclosure in writing. You may withdraw this consent in writing at any time.
2) The disclosure is allowed by a court order or a demand by Arizona Board of Behavioral Health Examiners.
3) I have information regarding physical harm to any person or a threat to commit physical harm to any person (including yourself).
4) I have information regarding suspected or perpetrated child abuse or neglect.

As a professional counselor I am continuing to work to improve my skills and our work together. I may seek consultation about your case with another licensed professional. If that were to occur I would protect your identity and only share information relevant to the improvement of MY work with you.

You may request in writing the information in your records be provided to you and I will work with you to provide you the information you are requesting.

Financial Policy

Fees: **Fees for sessions are $100 for a sixty minute session.**

Contact Outside of Sessions: Contact outside of your session is available on a limited basis and as my schedule allows, Monday through Friday, 9am to 6pm PST. For occasional support, the first 15 minutes are free. Above that the same rate for in-person sessions apply.

Cancellations: **Please provide at least 24-hour notice to cancel a session or you will be charged for the full session fee ($100).**

Payment Method: You may pay by cash, check, money order or credit card prior to or at the time of session.

(Financial Policy continued next page)

Financial Policy (Continued)

Insurance: I do not accept insurance. You may be eligible for out-of-network insurance benefits/ reimbursement for our work, as I am not a direct provider for any insurance plans. I do not accept insurance because I value my clients' privacy and feel that it is not in their best interest to report this information to insurance companies who require that you be given a mental illness diagnosis in order to receive services and may later deny coverage or a new policy based on this information. Please check with your insurance carrier to determine if you are eligible for out of network reimbursement. I am able to give you a "Super Bill" in order for you to receive reimbursements.

Changes: I reserve the right to change my fees with 30 days notice.

Agreement: by signing this document you are agreeing to pay for any services rendered.

Skype/Video/Phone Policy

It is important to understand the following limitations of Skype/Video/Phone contact, as well as expectations for each of us when using Skype/Video/Phone counseling treatment:

1) Any internet-based or phone-based communication is not guaranteed to be secure/ confidential.

2) There are precautions that you can take to increase security including:
   a. Ensuring that you are online in a private room/area with the door closed.
   b. When speaking by phone I will confirm your identity for your security.
   c. Whenever possible, connect to the internet directly (as opposed to using WiFi; this will also help with transmission)
   d. When our session is over be sure to turn Skype/Video/Phone of, not just disconnect from the call.

3) There is always the possibility of technology failure. If the technology we are using fails, we will contact each other via an alternate method to continue the session or to reschedule. If you are unable to reach me and are having an emergency, please call 911.

(Skype/Video/Phone Policy continued next page)

Skype/Video/Phone Policy (Continued)

4) Make the same commitment to our online session that you would to an in-office appointment:
   a. Please be on time.
   b. Limit distractions: turn off cell phones; avoid "split screens." Explain to others that you are unavailable for the next hour.
   c. Have your computer on a firm surface and sit on a sofa/chair or at a desk if possible.
   d. Check the audio/visual in the "preferences" each time before a session so that you can see what I am seeing (and vice versa).

5) Note that an Online session is still subject to the 24-hour cancellation policy.

Credentials

Arianna Gray has been serving in the mental health field for more than seventeen years, working in addiction treatment, hospice, child and family counseling, and general practice. She holds a Masters Degree in Counseling, with an Emphasis in Grief and Loss, from Southwestern College in Santa Fe, NM and is a Certified Clinical Hypnotherapist from the Institute of Therapeutic Learning in Seattle, WA. Arianna is a member of the Arizona Counseling Association and the Arizona Integrative Wellness Coalition. **Arianna is a Licensed Professional Counselor with the State of Arizona in the United States of America, License Number LPC-1446.**

Treatment Decisions

You are in charge of your own counseling, just as you are in charge of your own life. I am working in your interests. You can determine what your goals are and my role is to help you reach them. I may show you how to define your goals or show you what the consequences of reaching these goals might be, but you have the last word on this. We both agree that your goals can be changed at any time. It is also your right to end counseling at at any time. I encourage you to communicate with me about this ahead of time as “endings” are as important as beginnings and can be very transformative when done consciously.

Emergencies

Although I will be as supportive as possible in times of crisis, **our work together is not crisis counseling**. **By signing this document you agree that if you feel that you are in a life threatening emergency you will** contact the Southern Arizona Mental Health Corporation at 520-617-0043 (if in Arizona), go to your local hospital or **dial 911**.

Client Counselor Relationship

The counselor/client relationship is unique in that it is exclusively therapeutic. In other words, it is not appropriate for a client and a counselor to spend time together socially or to attend family or religious functions. The purpose of these boundaries is to ensure that you and I are clear in our roles for your counseling process and that your confidentiality is maintained. Additionally, if there is ever a time when you believe that you have been treated unfairly or disrespectfully please talk with me about it. I want to address any issues that might get in the way of your counseling. This includes administrative and financial issues as well.

After reading this consent information, please feel free to talk with me about any questions you might have. I look forward to our work together.

Arianna Gray, LPC