



Marcie Edmonds, MC, LPC  
Licensed Professional Counselor

## **INFORMED CONSENT**

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This document contains important information about my professional services and business policies. Please read it carefully and ask questions if you have any. Once you sign this, it will constitute your consent for us to begin therapy/treatment.

### **SESSIONS**

The purpose of the first couple of sessions is to become acquainted with each other, discuss the issues, and identify the problems you want therapy to address. This is called the assessment phase of therapy. Research confirms that the most important factor in explaining the results of therapy is the clinician-client relationship. It is therefore important that you determine during the assessment phase if (1) you like working with me, (2) you feel I understand your problem(s), and (3) you believe I am addressing them in a way that is meaningful and helpful to you. Our first session is one of the most important. During this session, I will want to get to know you, get an idea about the problems you are experiencing, and allow each of us to assess our compatibility to work together. Please feel free to ask me any questions so that your decision to work with me is as informed as is reasonably possible. Session frequency should largely be determined by you, depending on the distress you are experiencing. Sessions are 50 minutes in length. **I require that you pay for missed appointment unless you provide me at least 24 hours notice. Payment for late cancelled (less than 24 hours notice) or no-show sessions must be made prior to scheduling any future session(s).**

### **TELEPHONE CALLS**

I schedule my appointments personally. You can reach my voice mail at 602-460-8270. Please leave your name, return phone number, and a brief message. I will return your call as quickly as I am able, within 24 hours, Monday through Thursday. The telephone is typically not the best venue to address therapy issues. I do not provide emergency mental health or crisis services. If you have such an emergency, please call 911, or use the free crisis services in Maricopa County by dialing 602-222-9444 or 480-784-1500. Telephone counselors will talk with you and attempt to help you resolve the emergency over the phone. In cases of extreme distress, or that involve issues of personal safety; they are authorized to dispatch a crisis team, headed by a master's level mental health clinician, to your home or a place of your choosing to help you. Again, there is no fee for this service and services are confidential. To insure confidentiality, I do not correspond with clients by email regarding any clinical issues.

### **PROFESSIONAL FEES**

I base my fees on the time I spend with you and on your behalf. My fee for your initial intake (80 minutes) is \$225.00, sessions after that are \$150/counseling hour (50 minutes).

I will inform you of outside groups, workshops, and/or seminars that I believe will be helpful to you. I will notify you of these workshops, their topics and dates, and allow you to decide if they are relevant to you.

I do not provide expert witness, expert testimony, or private family evaluation services. I do not personally offer psychological assessment, testing, or test interpretation. I will be happy, however, to refer you to qualified professionals who offer these services if I think it would be helpful to you, or if you request it.

All fees are subject to change, and in the event of fee changes, you will be notified at least 30 days prior to such changes. There is a \$30.00 service charge on all returned checks. Should a check be returned to me unpaid, the original unpaid check, along with the service charge, must be paid prior to continuation of services.



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## **INFORMED CONSENT – (CONTINUED)**

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### **BILLING AND FEE PAYMENT**

Fee payment is expected at the conclusion of each session. I accept cash, check, most debit cards, money orders, and the following credit cards: VISA, MASTERCARD, American Express. Because I am not an in-network insurance provider, I am unable to bill your insurance for services I render to you or on your behalf.

Your privacy and your right to control who knows what about you is of significant concern to me. Insurance companies and managed care companies almost always require outpatient treatment plans or reports as a condition for certifying or recertifying treatment. Information requested may be as simple as a diagnosis and type of treatment, but may also be of a personal nature requiring more detailed information. Some companies have even requested a copy of the entire record. This information will become part of the insurance company's files, and in all probability, some of it will be computerized. All insurance companies/managed care companies are required by law to keep such information confidential, but once it is in their hands, I have no control over what they do with it. In some cases, they may share the information with a national medical information data bank (such as the MIB – Medical Information Bureau.) Because of the potential for loss of your privacy and confidentiality, even if unintentional, you may, like many clients, prefer to pay "out of pocket" and not file mental health insurance claims. I will, however, gladly provide you with the information you need to file your own insurance claims. You simply need to request the needed information from me.

### **CONFIDENTIALITY**

Within the limitations discussed below, the information you reveal to me during our professional relationship will be kept confidential and will not be released to anyone without your written consent. However, certain conditions do require, in keeping with my professional Code of Ethics and the mental health laws of Arizona, that confidentiality and privileged communications be breached including: (1) if you present a danger to yourself; (2) if you present imminent danger to another person; (3) if there is reason to believe that child abuse or neglect is present; (4) if a legitimate court order is issued; (5) if the treatment is ordered or under the supervision of the court; and (6) if an insurance company or managed care company requires you to consent to release of records and/or information to them as a condition for reimbursement. Under the legal statutes that govern the practice of mental health in Arizona, I am not required to inform you of my actions in this regard when it becomes necessary. I will discuss minor children's rights to confidentiality with both the parent(s) and the child(ren) and I will make decisions about child confidentiality on a client by client basis.

I will obtain from you a separate release of information authorization when you wish to request or allow me to communicate with others about therapy issues. When this information is released, however, I cannot control how the information is treated. Your signature is your agreement that you understand that I will not be responsible for any injury or claim for damages arising from the release of records or information that has been conveyed to others, whether without your permission (when the release of information is required by law), or with your permission, including but not limited to doctors, other mental health professionals, school teachers, insurance companies and/or managed care organizations.

With the exception of fax transmission and telephone conversations, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 places severe limitations and restrictions on the electronic transfer of client information and records, thus requiring a significant investment of capital in software and manpower to protect your confidentiality, and to manage this information. To keep the cost of my services reasonable, I will, therefore, not



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**INFORMED CONSENT – (CONTINUED)**

transmit any of your information electronically; i.e., email, email attachments, website, electronic claims, etc., nor will I be able to communicate with you via electronic means other than telephone and fax.

Information revealed in marital therapy is protected by privileged communication in Arizona and requires permission of both spouses to waive that privilege. In other words, what one spouse says during a therapy session to or about the other spouse may not be revealed to anyone other than the other spouse unless both spouses sign a consent to reveal that information. When working with couples, I adopt a “no secrets” rule.

**Special Note:** When a family is confronted by parental separation or divorce, it is very hard on everyone. It is important then, when working as a couple, that each person feel safe to speak openly and honestly, without fear that the information revealed in therapy will be used in court by one spouse/parent against the other spouse/parent. In order to provide a safe environment for couples work, it is important that you agree not to call me as a witness or to attempt to subpoena records in the event you choose to pursue divorce. Though a judge may overrule this agreement and may issue a court order for information, your signature(s) below reflect your agreement not to call me as a witness nor attempt to subpoena clinical records.

In order to provide clinical coverage for me when I am out of town, it may be necessary for me to release general information to the clinician who covers for me. If I am going to be out of the office, I will make every effort to inform you who is covering for me, and let you know the type of information that I may need to share with him/her. However, if an emergency required me to be out of the office suddenly, I would be guided by the American Counseling Association regarding the type of information disclosed. I will leave a recorded message on my voice mail if I plan to be out of town.

**AGREEMENT**

I have read this information fully and completely, I have discussed any questions I had about the information, and I understand the information. I understand that there are no guarantees stated or implied, and I accept the risks inherent in the course of therapy. I have familiarized myself with the fees and charges for services provided by Marcie Edmonds, MC, LPC, and I understand and agree that the therapy services rendered will be charged to me and not to any third-party payer. I acknowledge responsibility for payment of services, and I understand I am responsible for all costs of collection and litigation together with attorney’s fees if the charges for services must be collected by an action of law. If I choose to seek reimbursement from my insurance company for the fees I pay, I consent and agree that Marcie Edmonds, MC, LPC, may release such information required by my insurance company and/or managed care company for payment for services rendered, and I agree to hold Marcie Edmonds, MC, LPC, harmless for any injury or claim for damages arising from release of records or information as required by my insurance company/managed care company. I hereby acknowledge that I have been informed that no one can predict the course of human relationships, and as we learn more about each other, it may be necessary to amend prior agreements.

Client: \_\_\_\_\_ Date: \_\_\_\_\_  
Client: \_\_\_\_\_ Date: \_\_\_\_\_  
Client: \_\_\_\_\_ Date: \_\_\_\_\_  
Client: \_\_\_\_\_ Date: \_\_\_\_\_

(Minor child under age 18)

