James Goodmon Counseling, LLC

Informed Consent

Thank you for choosing James Goodmon Counseling, LLC to provide you with counseling services. Indiana law and the ethical standards of the counseling profession require that you be provided with information regarding your rights and responsibilities as a client and the limits of confidentiality. If you have any questions or concerns please discuss with your counselor.

CLIENT RIGHTS: **Initials_____**

To have the counselor available at the agreed upon appointment time.

To understand any issue related to treatment of the counseling process.

To ask questions about your counselor, the counselor's modalities, and/or the process.

To discontinue counseling at any time.

To request a change of counselor.

CLIENT RESPONSIBILITIES: **Initials_____**

To arrive for counseling sessions on time. Each session is **45-50 minutes**. If you are late, you will lose session time, as session will end at designated time.

Contracted payment is expected at each session. Please bring with you cash, check or credit card, FSA or HSA cards.

To cancel an appointment **24 hours** in advance is needed. **Full payment is charged** for missed appointments or no shows. Frequent cancellations may result in termination of the counseling relationship.

To cooperate with the client's counselor in the therapeutic process.

To contact one of the following emergency resources for immediate assistance or emergency.

IU Health E.D. – 812-353-5010

National Suicide Prevention 24-hour crisis line - 800-273-8255.

If unable to reach above resources, please contact 911

LIMITS OF CONFIDENTIALITY: **Initials_____**

The results of treatment or tests must be revealed to the courts when a client has been ordered into treatment by the court.

Legal exceptions to confidentiality: A counselor may take steps to protect a client or others from imminent danger, when a client threatens physical injury to self and others, (suicidal or homicidal). Client presents with a grave disability from a mental illness. A counselor must report disclosures or reasonable suspicion of physical or sexual abuse or neglect of a minor to the local department of children's services. A counselor must report abuse, neglect, or domestic violence for endangered adults.

Counselor's may consult with a licensed supervisor about a client's progress.

Records are subject for disclosure in accordance with legal requirements.

Indiana Law requires a mental health provider to warn third parties if a mental health client has been diagnosed with HIV/AIDS and has expressed intention to harm an identifiable victim.

In couple and family therapy, or when different members are seen individually, confidentiality and privilege do not apply between couple or among family members. Your counselor will use her/his clinical judgement when revealing such information.

COMMUNICATION: **Initials_____**

Client understands it is impossible to protect the confidentiality of information that is transmitted electronically, such as; email, text, voicemail, Skype, FaceTime and information stored on computers which do not utilized encryption and other forms of security protection.

EMAIL: **Initials_____**

Unencrypted email is neither private or confidential. We recommend only corresponding with counselor regarding administrative issues. Counseling via email is not conducive to privacy.

SOCIAL MEDIA: **Initials_____**

Therapist do not accept friend requests from current or former clients. We believe this may compromise confidentiality.

BENEFITS AND RISKS OF COUNSELING: **Initials_____**

Counseling may result in a number of benefits such as; reducing psychological symptoms, improving interpersonal relationships, increasing personal growth, and resolving conflicts. Counseling requires active involvement, honesty, and openness in order to grow, change, and heal. During counseling, you may experience discomfort in regard to past hurt and trauma. At times things may get more difficult before they get better, there is no guarantee of positive result.

AGREEMENT WITH:

By signature below, in exchange for counseling services, please confirm and agree to be bound as follows:

I understand that James Goodmon, LMFT, will attempt to assist me in developing an emotional/mental health plan and that he does not make any representations or guarantees with results of therapy. I understand that James Goodmon, LMFT may consult with licensed counselors to discuss various aspects of cases with anonymity. The undersigned further acknowledges that this is a full and complete release for all injuries and damages, which the undersigned may sustain as a result of participation of these services.

CLIENT:(S)

_____ _____ _____

Printed Full Name of Client Signature of Client Date

If client is under 18 years of age:

_____ _____ _____

Printed Name Parent/Legal Guardian Signature of Parent/Legal Guardian Date

_____ _____ _____

Printed Name of Counselor Signature of Counselor Date