Dover Counseling Services, Inc.

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Informed Consent for Therapy

Thank you for coming to Dover Counseling Services, Inc. and allowing us the opportunity to provide you and/or your family with therapeutic services. Please read the following information prior to consenting for therapy and initial each paragraph.

_____ **Confidentiality**: What is discussed in therapy is confidential. Information concerning your case will not be released to anyone outside of Dover Counseling Services, Inc. without your written permission to do so. If therapy involves more than one individual, permission must be obtained from all individuals in order for information to be released.
A legal guardian/parent must provide this permission for minors.

Exceptions to confidentiality:

1. Duty to warn: I will abide by the laws of the State of Alabama in regards to the duty of therapists to warn whenever there is a reasonable probability of willful harm to self or others. This includes warning identified victims and informing authorities.
2. Judicial Subpoena/Court Order
3. Mandatory reporting of child abuse/neglect: If at any time I suspect child abuse or neglect I am mandated by state law to report it to the state and/or law enforcement for investigation.

_____ **Confidentiality within Individual and Family Therapy**: When working with an individual, I may from time to time conduct family sessions. Information from individual sessions will not be shared with family members unless I am given permission to do so. Information shared within family therapy will be kept confidential by me; due to numerous participants, however, privacy is naturally dependent upon each client's willingness to submit to standards of confidentiality. If you wish to provide me with information that you do not want shared with the other therapy participants, you must inform me of this request. If I deem that keeping the information confidential from the other family member would be dangerous to the individual, then the information must be shared.

_____ **Fee**: Most insurance policies cover mental health counseling. If your policy does not cover, my fees are as follows: Initial visit $155 and individual and/or family counseling sessions range from $120-140 per visit. **There is some variation to this, however, which I will discuss with you before the session begins.** Payment and/or co-pay is expected upon checkout after each therapy session. If payment is not received within 60 days your account may be turned over to a collection agency. Failure to cancel appointments without 24 hour notice and/or failure to attend a scheduled appointment (**no show**) will result in being billed a $35.00 no show fee, which must be paid prior to the next session. If you do not show for an appointment within 15 minutes of the start time and you have not contacted Dover Counseling Services, Inc., it will be assumed that the appointment is cancelled without prior notice and you will be subject to the no show fee.

_____ **Insurance:** If you wish for me to file on your insurance, by signing this informed consent you are agreeing for me to disclose required information from your chart. This will include client demographics, diagnoses, and dates of service.

_____ **Court Appearance**: I will not make court appearances in a custody case in order to testify on behalf of **one parent over another**. However, I will occasionally testify on behalf of a child involved in a custody battle in order to make their wishes more clearly known to the court. My court cost is $200 per projected hour* paid

prior to taking the stand. All parties involved in therapy must sign a release of information in order for me to divulge any confidential information.

_____ * Per projected hour: Attorneys will often request that an expert witness be given a designated time to present at court for their testimony. As such, all clients already scheduled during that period of time must be rescheduled. Therefore, even if the testimony does not result in all the projected time being spent, I cannot recoup the lost wages for those rescheduled clients. If the time required extends beyond the projected time, you will receive an extra charge at the same rate per additional hour required for testimony.

_____ **Records Release/Attorneys**: If you or your child is involved in a court case, and you need information from the counseling sessions, progress notes will not be released without written consent from all parties involved. Additionally, releasing actual progress notes, as opposed to session summaries, puts clients at risk of having privileged communication disclosed to unintended parties. For example, any progress notes submitted to a court proceeding will become part of the court records, and will be available for scrutiny by your attorney and the opposing attorney. It is therefore recommended that only session summaries be requested.

_____ **Referral**: I am ethically bound to terminate the therapy contact if the therapy relationship is deemed no longer beneficial to the client. Should this occur, I will be able to provide you with another therapist as a referral. You may choose to use the referral therapist, another therapist of your choice, or to stop therapy altogether.

_____ **Withdrawal from therapy**: You may terminate the contract at any time. However, please discuss the decision to terminate with me rather than simply "quitting." Missing two (2) successive scheduled appointments or not attending therapy for more than one (1) month without prior notification will be considered withdrawal from the therapy contract. Should this occur, all existing scheduled appointments will be cancelled and your therapy sessions will be considered terminated. Any no show appointments without making contact will result in the cancellation of all future scheduled appointments.

_____ **Video/Online Sessions:** When appropriate and agreed upon by both the client and the therapist, video/online therapy sessions may be conducted. Therapists at Dover Counseling Services, Inc. utilize doxy.me, a HIPPA-compliant online therapy platform. Specifics of this service and the possibility of using it are discussed between client and therapist. If you and your therapist choose to utilize video sessions, by signing this informed consent, you are giving permission to participate in video sessions.

_____ **Letters and/or Forms:** Due to the time involved in writing letters a fee of $10.00 is required per page for diagnosis letters and $60.00 an hour for summary/recommendation letters. Payment is due the day the letter is received. A $40 fee is also required for completing disability insurance forms as this is also a time-consuming task. Payment is due the day the forms are picked up from the office.

_____ **Accessibility**: In the event of an emergency dial 911 or visit your local emergency room. If you leave a message for me at 334-417-0212, I will do my best to return your call before the next business day. Many of the therapists at Dover Counseling offer their cell phone numbers to be used in cases of emergency, as well.

_____ **Scheduling:** You will receive a reminder call, text, or email a day prior to your session. Occasionally, if you are on my wait list, you may also receive a phone call or text message informing you of an opening in my schedule. By signing this informed consent, you are giving me permission to contact you via text, phone, or email.

_____ **Outdoor Therapy Liability Release:**
I, a client of Dover Counseling Services, Inc., grant permission to Dover Counseling Services, Inc. therapists to take myself or my child walking around the area surrounding the counseling office from time to time.

I, the undersigned, understand and acknowledge that neither Amy Dover, my specific therapist, nor Dover Counseling Services, Inc., nor any of its officers, agents, directors, affiliates, or employees shall be held responsible for any act, accident, or injury in any way related to my, or my child's, outside therapeutic session, and further acknowledge that I am aware that said outdoor therapeutic session is being offered as a part of my, or my child's, therapy with Dover Counseling Services, Inc. and that there is no requirement that said therapy is required to take place outdoors.

In consideration for my therapy by Dover Counseling Services therapists, I, the undersigned, for and on behalf of myself, my family, and my estate, heirs, and assigns, do hereby release, indemnify, and hold harmless all therapists at Dover Counseling Services, Inc., including its officers, agents, directors, affiliates, and employees, from and against any and all claims, actions, damages, liability and expense in connection with claims (including attorneys' fees), whether in statutory or common low, in law or in equity relating to injury, including death, or damage to myself or my child or property belonging to me, relating to or arising from my outdoor therapy provided by the therapists at Dover Counseling Services, Inc.

I hereby certify that I am fully competent to sign this Informed Consent, and this Outdoor Therapy Liability Release ("Release") and that I have read the Release in its entirety and agree to be fully bound thereby.

Notice of Privacy Practices: I, a client of Dover Counseling Services, Inc., hereby acknowledge that I have received a copy of the HIPPA/privacy practices for Dover Counseling Services, Inc. My initials indicate that I was offered a copy but declined to take it.

_____ Initials

Client Information

Client's name: _____

Client's address: _____

Phone numbers: Home_____ Cell_____

Email: _____

Emergency Contacts

Name:_____ Phone:_____ Relationship_____

Name:_____ Phone:_____ Relationship_____

Please feel free to ask me about any concerns you may have. By signing below you indicate that you understand the policies set forth by this informed consent, agree to abide by them, and are 14 years of age or older.

_____ _____

Client or guardian Date Witness Date

Dover Counseling Services, Inc.
Minor Consent for Therapy

I/We, _____, am the parent or guardian of: (list all children under the age of 19 who will be participating in therapy)

Child's Name	Child's Date of Birth

And I/we give consent for him or her to participate in therapy.

Parent/Legal Guardian	Date
Parent/Legal Guardian	Date
Witness	Date