INFORMED CONSENT

Thank you for choosing Korey Eckley, LCSW. Today's appointment will take approximately 45 – 50 minutes. Realizing that starting counseling is a major decision and you may have many questions this document is intended to inform you of policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and Korey Eckley will try her best to give you all the information you need. Korey Eckley, LCSW has earned a Bachelor of Arts Degree in Psychology from Indiana University and a Masters Degree in Social Work from the University of South Carolina. She is licensed by the State of Indiana and Illinois as a Licensed Clinical Social Worker. She has over 8 years (5 years post masters) of clinical experience in treating adolescents, adults, and families using individual, family therapy, and group therapy. She specializes in adjustment to illness (new diagnosis, chronic, or terminal), grief and loss, relationship transitions, and anxiety. Korey Eckley practices standard cognitive behavioral therapy, solution focused, and psychodynamic therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information shared with designated psychiatrist (either referred by Korey Eckley or of your own), b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Indiana State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, and I call is not returned within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Korey Eckley will follow those emergency services with standard counseling and support to the client or the client's family.*

Signature(s)____Date:________

FINANCIAL/INSURANCE ISSUES: *As a courtesy Korey Eckley will bill your insurance company, HMO, responsible party or third party payer for you if you wish. Korey Eckley asks that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an*

account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Korey Eckley

I have received a copy of my fee schedule ________________

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be <u>*billed at the hourly rate*</u>*. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.* ***You may have a copy of this form if requested.***

Signature(s)____***Date***________

<u>COORDINATION OF TREAMENT:</u> *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year.* ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no inform will be shared.*

____You may inform my physician(s) **____I decline to inform my physician**

PHYSICIAN NAME:____
CLINIC:____
ADDRESS:____
PHONE:_____________________________________

Signature(s)____***Date***________

<u>NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS</u>: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

Signature(s)____**Date**_______________

May we contact you at home (circle one) ***yes no****? May we contact you at work* ***yes no?*** *May we contact you by cell phone* ***yes no?*** *Where may we contact you* _________
____*?*

<u>CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:</u> *I/We consent that* ____ *maybe treated as a client by Korey Eckley. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.*

Signature(s)____***Date***___________