Westside Christian Counseling Center
Informed Consent for Therapy

It is important for you, as a client of Westside Christian Counseling Center to be fully informed about the therapy services you will be receiving. Your signature below indicates that you have received, read, and understand your rights and responsibilities under this agreement and agree to enter a therapy relationship with Westside Christian Counseling Center upon the terms of this agreement.

The Process of Therapy
The therapist will work with you to identify presenting issues and develop a treatment plan to assist you. Unlike a medical doctor visit, professional therapy calls for an active effort on your part. Change is facilitated as the client and therapist establish a mutually respectful partnership. The therapist will facilitate a process of communication and provide knowledge based on your growth and development. It is your obligation to identify personal goals towards which you desire to move and obstacles which may prevent that movement. The purpose of this process is to enable the client to move toward greater mental, physical, spiritual-growth and satisfaction. While the process is effective for many people there are no guarantees of success.

Professional Disclosure Statement
Westside Christian Counseling Center is a Christian based ministry to serve those who need assistance. Westside Christian Counseling Center works from a Christian perspective and strive to integrate the truth of theology and marriage and family therapy. We emphasize communication and responsibility within a systems framework and utilize a variety of modalities to promote the healing process. We provide individual, couple, family and group therapy. We are committed to respecting the values of each person and give each client a safe place in which to seek growth.

Practical Issues
1. The State of Kansas, through the Behavioral Sciences Regulatory Board (BSRB), licenses mental professionals. As Licensed Mental Health Professionals, we are committed to practice according to the ethics of our profession. We uphold the American Association of Marriage and Family Therapy Code of Ethics. A copy of our code of ethics is available upon request.
2. As Mental Health Professionals we are ethically and legally committed to the confidentiality of client disclosures. Exceptions are the following:
a) a client is a danger to self or others;
b) when there is a reason to suspect abuse or neglect of a child, an elderly person, or a disabled adult; and
c) when the judicial system orders client records to be made available.

In keeping with accepted professional practices, sometimes we request a client's permission to consult with other professionals about the client's situation. A release of information form is provided for the client to indicate they are authorizing this professional to discuss case information as needed with our Counseling Center therapists, and clinical supervisor for oversight and consultation and grant that permission in writing by signing this form. As a counseling center we operate under the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I acknowledge that I have received a copy of the Westside Christian Counseling Center's Notice of Privacy Practices with the effective date of April 14, 2003.

3. In addition to the exceptions of confidentiality listed above, third party payers require information before they will reimburse clients for their fees. Some insurance cases are accepted, and I do offer a payment plan for those who can not pay the full amount each session. Additional information of fees will be provided if needed. The standard fees for services are: initial session $150.00/LCMFT or $120.00(LMFT); subsequent sessions $110.00(LCMFT) or $90.00(LMFT) per clinical hour. A standard session is 45 minutes in length. If additional time is needed, additional fees will be applied.

4. If the treatment we provide is covered by health insurance, you should note that many times "Managed Health Care" plans such as HMOs and PPOs require prior authorization before they will provide reimbursement for our services. If your contract with your insurance company requires that we provide it with information relevant to the services we provide we may be required to provide them with a clinical diagnosis, as well as clinical information such as treatment plans or summaries and/or copies of any records we maintain about your therapy sessions. By signing below, you acknowledge and consent to such disclosures.

5. If a therapist is subpoenaed to testify or submit records to the court, a fee will be assessed. For a written report a fee of $200.00 will be charged. For testifying locally, the therapist will bill $100.00 per clock hour on site, and may bill up to $100.00 per hour for preparation time. If out of state, travel expenses will also be billed.

6. If a client contacts a therapist by phone, after 10 minutes, a fee will be charged comparable to prorated sessions fees. The client will be responsible for these charges, as they cannot be billed to insurance.

7. In working to achieve the potential benefits of therapy, it may require that you, the client, make firm efforts to change. This may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events that can arouse intense feelings of fear, anger, depression, frustration, and the like. Seeking to resolve issues between family members, marital partners, and other persons can similarly lead to discomfort, as well as relationship changes that may not be originally intended.

8. Within the context of couple or family therapy, it is the practice that whatever is shared with the therapist jointly or privately is material that is open to be shared in session. This will be left to the professional judgment of the therapist.

9. Clients who need to cancel appointments are requested to do so at least 24 hours in advance. If a client does not show up for an appointment or provide at least 24 hours' notice, a $25.00 charge will be assessed for the first occurrence. For the second occurrence, a full session fee will be applied. Exceptions may be warranted in the event of an emergency. Appointments can be scheduled or cancelled by contacting the office at 316-440-8928. If for some reason, your therapist must cancel an appointment, he or she will call you at the number you have provided and, if you are not there, will leave a message stating, "This is [your therapist's name] and I will be unable to keep our appointment today." **If you do not want us to contact you in this manner, please notify us so that we can discuss any alternative arrangements.**

10. Co-payments are expected at the time of the service. You may pay with cash or check only. A $30.00 charge will be assessed for returned checks.

11. Clients will have a file created in his, her, or their name(s). The purpose of this file is to help the therapist remember relevant information and to carry out his/her responsibilities effectively and efficiently. Files will be maintained for seven years after termination of the counseling relationship at which time the file will be shredded.

12. If a client is in crisis, your therapist will make arrangements for you to be able to contact him or her after hours. This is to be used for emergency purposes only.

I have read the information above and choose to enter into a therapy relationship under the provisions described.

Client or Authorized Representative Date	Relationship to the Client if applicable
Client Date	Client Date
Client Date	Client Date
Client Date	Client Date
Therapist Credentials Date	Therapist Credentials Date