**Laura Willenborg Counseling Services, LLC**

**Confidentiality**

Welcome to Laura Willenborg Counseling Services, LLC, and thank you for entrusting me with your care. I encourage you to be an active participant in your counseling, and I welcome your feedback to assist me in directing your care. I also encourage active participation of family members and loved ones, as we find appropriate throughout the process.

Please familiarize yourself with my office policies.

1. Your treatment is confidential: No one may have access to your records or the information shared in your appointments without your specific permission or the permission of a legal guardian (e.g. written ‘Release of Information’).

The noted exceptions to this rule are as follows:

* 1. Provider believes the client to be a danger to him or herself or others.
	2. Provider believes a child or elderly adult is being abused or neglected.
	3. Parents or legal guardians of non-emancipated minor client have the right to access client records as requested.
	4. Records are required by court subpoena.
	5. Insurance companies and other third-party payers are given information requested regarding services to clients.

In the event of any of these exceptions, the provider has a moral, legal, and ethical duty to break the client’s confidentiality in order to intervene appropriately.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

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Client Signature (Client’s Parent/Guardian if under 18 years of age)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date

**Laura Willenborg Counseling Services, LLC**

**Cancellation and Payment Policy**

Please call or text me at **765-413-5835** to cancel your appointment. Cancellations or changes must be made 24 hours in advance of the appointment. Cancellations made with less than a 24 hour notice, will be charged a $40 fee at the discretion of the provider. Missed appointments without any notification will be charged a $40 fee.

Appointments will be cancelled if you do not arrive within 15 minutes after the beginning of your scheduled appointment time.

Repeating appointments may be scheduled. This service is provided as a courtesy. Any repeated cancellations or missed appointments may result in the cancellation of subsequent appointments.

Any outstanding balance will be due prior to being seen for additional appointments. Payment for the initial assessment will be due before services are provided.

This policy is not meant to be punitive, but meant to provide the most quality care through accountability and with respect to the provider, as well as to the needs of all clients scheduling.

*By signing this policy, you are agreeing to the above conditions.*

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Client Signature (Client’s Parent/Guardian if under 18 years of age)

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Today’s Date

**Laura Willenborg Counseling Services, LLC**

**Discharge Policy**

To make the best possible use of therapy it is important that you attend regularly scheduled appointments, and take an active role in your care. In order to maintain a good balance of care, if you do not participate in therapy for 90 days, your file will be considered closed. Similarly, if you miss 2 or more appointments in a row, your file may be closed. You are free to contact the provider and return to therapy at any point, at the discretion of the provider.

By signing this policy, you are agreeing to the above conditions.

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Client Signature (Client’s Parent/Guardian if under 18 years of age)

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Today’s Date

**Laura Willenborg Counseling Services, LLC**

**Financial Responsibility**

I accept full financial responsibility for any and all charges for counseling services provided. My insurance will be billed as a courtesy, but I accept responsibility for any amount not covered by insurance. This includes payment for cancelled or missed appointments with less than a 24-hour notice.

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Client Signature (Client’s Parent/Guardian if under 18 years of age)

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Today’s Date

**Credit Card Authorization**

I am pleased to accept Visa, Mastercard, or HSA cards as payment for services rendered. If you have insurance, your insurance will be billed, and the remaining balance will be charged to your card. Should there be discrepancies between a previous payment and an insurance reimbursement, the remaining balance will be charged to your card at that time. There will be notification via phone or email that this charge is being made. Any fee related to a late cancellation or no-show appointment will be charged the day of the scheduled service.

Client Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ RECURRING CHARGE AUTHORIZATION: The undersigned card member consents and permits Laura Willenborg Counseling, LLC, as applicable, to charge my Credit Card Account specified below, or to any other Credit Card Account of mine that I may specify in the future, the amounts due from me for services provided to me during the applicable billing cycles. I release Laura Willenborg Counseling, LLC, as applicable, from any and all claims arising from the use of this service. I understand and agree that Laura Willenborg Counseling, LLC, as applicable, may continue to charge such amounts to my Credit Card Account until receiving notification from me that I have withdrawn this consent and permission, at which time, Laura Willenborg Counseling, LLC, as applicable, shall cease charging any such amounts to my Credit Card Account.

**Credit Card Information**

Name as it appears on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ -- \_\_\_\_\_\_\_\_\_\_\_\_\_ -- \_\_\_\_\_\_\_\_\_\_\_\_\_ -- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Billing Address:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

By signing this policy, you are agreeing to the above conditions.

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Client Signature (Client’s Parent/Guardian if under 18 years of age)

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Today’s Date

**Laura Willenborg Counseling Services, LLC**

**Release of Liability for Animal Assisted Therapy**

My business associate utilizes a therapy dog. Augustus “Gus” will be attending counseling sessions with my associate in the office next to mine. The office has shared space, and Gus may be present at times in this shared space. Gus will not be present during our therapy sessions, but there may be occasional contact with Gus before or after your appointments. By signing this form, you are releasing Laura Willenborg Counseling, LLC and Holen Blackburn Counseling Services, LLC, from any liability should any issue or injury occur as a result of being on the property of 1000 Sagamore Pkwy N, Suite 207.

If you or anyone involved in your counseling has a concern regarding dogs, pet allergies, or otherwise, please contact me about this concern prior to your initial assessment.

If you have any other concern about Gus’s presence in the office, please contact me prior to your initial assessment. It is your responsibility to inform any guests to your sessions about Gus’s presence and the potential risks involved.

By signing this policy, I acknowledge and accept the risks involved.

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Client Signature (Client’s Parent/Guardian if under 18 years of age)

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Today’s Date

**Laura Willenborg Counseling Services, LLC**

**New Client Information**

**Initial Assessment**

The first appointment will be an initial assessment. The purpose is to gather information, and to begin identifying goals to assist in guiding your treatment. You are asked to complete the initial assessment forms prior to the appointment, and to arrive 10 minutes before the start of your initial appointment.  The assessment will last approximately 1 hour.

**Therapy Sessions**

Individual therapy or family therapy sessions are available. Each session will last between 45-50 minutes in length. If sessions are longer than this, billing will be increased. The number of sessions needed can be determined as each client’s needs are evaluated. It is important to me that your experience in therapy meets your needs, so if a referral to another provider is needed, we can identify this as well.

**Goals**

Each client will identify their own goals for therapy as well as have recommendations given for a course of treatment that appears to best suit each individual.  Goals for therapy may be reviewed and updated at any time, and you may receive copies of your identified goals, as requested.

**Satisfaction**

Typically, at the end of each session, I will stop our session and ask how you feel about that session. This is a time to reflect on the session, summarize what you have taken away from the session, reflect on how you feel the session has gone, and to give me feedback as to how you feel the direction of therapy is going.

Open communication within the counseling relationship is very important. If a client is dissatisfied with any services or with the direction in which treatment is going, it is encouraged that this is communicated to the therapist. It is important to me that your experience in therapy meets your needs.

If it is determined at any time, by either the therapist or the client, that therapy is not currently meeting the client’s needs, this can be discussed and a referral to another therapist may be made.

**Voicemails/Emergencies**

During sessions, my business phone will be on silent. Please leave a message and I will return your call as I am able; it may take a couple business days for me to return your call. If you have an emergency, including concerns of acting on suicidal thoughts, call 911 or go to the nearest emergency room. You may choose to go to Sycamore Springs for an evaluation, if this meets your needs. They can offer intensive outpatient services (typically 3 times a week) as well as inpatient options.

**Flexibility**

Please understand that family is important to me. I have two young children, and there may be times in which I need to reschedule an appointment due to my child’s activities, illness or health appointments, etc. If this happens, I will try to contact you as soon as I can, as I understand this impacts your schedule as well. I will also try very hard to get your appointment rescheduled as soon as I am able. Thank you for your flexibility.