C^2 Counseling
Informed Consent Form

Please read the following carefully and initial where asked as it will represent an agreement between us.

I. CONSENT TO TREATMENT

I voluntarily consent and may end the counseling relationship at any time to allow counseling services, assessments, and treatments to my dependent _____ or myself _____. The Licensed Professional Counselor may consult with other counselors or psychologists in order to better conceptualize my case. Successful termination of services is determined when the counselor and I agree that the treatment goals are substantially completed. Termination may also occur if I miss two consecutive appointments without proper and timely notification.

_____
Your Initials

II. Treatment

I will be informed about the nature of the counseling assessment and/or treatment services that will be recommended. I will have the opportunity to discuss concerns and help in developing a treatment plan. I understand that during the time we work together, we will meet weekly or once every other week for approximately 45-55 minute sessions.

_____
Your Initials

III. Referrals

If the professional counselor or I feel that a referral is needed, she/he will provide some alternatives.

_____
Your Initials

IV. Confidentiality and Duty to Warn

I understand that my dependent or I have the right to privacy as protected by law. Generally, all communication between the client and the counselor is confidential. However, I am aware of the limits to confidentiality in which information may be disclosed under the following conditions:

A. Circumstances where either others or I are at imminent risk for serious injury (suicide) or death (homicidal).
B. Suspected abuse, including physical, mental, or sexual of a minor or disabled person, or elderly person.
C. Court order or referral for criminal court evaluation.

State law mandates that mental health professionals may need to report these situations to appropriate persons or agencies.

_____
Your Initials

In marriage and family counseling there are no secrets between partners, therefore the confidentiality is not guaranteed.

_____
Your Initials

V. Counselor's Incapacity or death

I acknowledge in the event the counselor becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. I give consent to allow another licensed mental health provider, selected by C^2 Counseling, to take possession of my file and provide me with copies upon request. I will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

_____
Your Initials

VI. Client Rights

I understand that I have certain rights, which include:

1. All civil rights guaranteed by Texas and the United States Law.
2. The right to be treated with dignity and respect without abuse or neglect.
3. The right to an investigation of a complaint. Every reasonable effort will be made to resolve disputes.
   - The contact phone number for the Texas State Board of Professional Counselors is 1-800-942-5540; the Board works to protect the public from unethical professional behavior or behaviors that violate the rules of practice for Licensed Professional Counselors.
4. The right to permit information to be released with a Signed Authorization for Release of Information Form indicating what information will be released, for what reasons, and to what party.

_____
Your Initials

VII. Records

I understand clinical records will be destroyed in seven years after my last session or in the case of my child, seven years after their 18th birthday. I also understand that C^2 Counseling is the custodian of records. If I request a copy of clinical records, there will be a fee. If I grant permission to another provider or organization to receive copies or faxes of my records, the fee will also apply.

_____
Your Initials

VIII. Fees

I understand that there are fees for professional services provided and that these fees have been discussed with me. I accept responsibility for the charges incurred. Payment is due at time of services unless arrangements have been made. I understand and accept that if I fail to pay for the services rendered by C2 Counseling, my name and information will be submitted to the Credit Bureau.

_____
Your Initials

The fee for missed appointments with less than 24 hours notice is $50 payable at time of next session. After two consecutive no shows without payment collected, the office will terminate services until payment is made.

_____
Your Initials

This contract does not include forensic services. A separate contract for forensic services will be delivered if needed.

_____
Your Initials

By signing below, I agree that I have read and initialed this document, understood it, have been given the opportunity to ask questions, and have access to a copy of the notice at www.yvonnecastillophd.com .

_____	_____
Print Client Name	**Date**
_____	_____
Signature of Client/Guardian	**Date**
_____	_____
Print Guardian	**Date**
_____	_____
Witnessed By	**Date**