Redemption Psychotherapy
Audrey Cooper, MA, LPC, SEP
405 S. Clairborne Road, Suite 1
Olathe, KS 66062
913-764-5463 (ext. 111)
audrey@lifelinecounselingcenter.org

Informed Consent for Individual Treatment

Thank you for giving me the opportunity to serve you on your journey toward health and wholeness. I pledge to give you the best care that I can and will deliver to you the highest quality of service. In order to meet your needs, the following information is provided for your consideration. Please read this carefully and ask any questions that you may have.

ABOUT THE COUNSELOR

Credentials: My name is Audrey Cooper, MA, LPC, SEP. I have a Master of Arts in Counseling from Regent University and hold the title of Licensed Professional Counselor in the State of Kansas. In addition to my formal education, I have obtained my Somatic Experiencing® Practitioner certificate through the Somatic Experiencing® Trauma Institute. Please refer to **Counseling Approach/Theory** for more information about Somatic Experiencing®. Be advised that I am not a physician and do not have the authority to prescribe medication.

Licensing Regulations: I am a Licensed Professional Counselor (LPC 3111) in the State of Kansas, working toward the completion of 4350 hours to become a Licensed Clinical Professional Counselor (LCPC). Please refer to the following address for more information pertaining to the Kansas Behavioral Sciences Regulatory Board:

Kansas Behavioral Sciences Regulatory Board
700 SW Harrison St, Suite 420
Topeka, KS 66603
(785) 296-3240
www.ksbsrb.ks.gov

Supervisory Relationship: I am currently under the supervision of Amber Johnson, LCPC, RPT-S. Supervision is important for my professional growth and necessary for completing the 4350 clinical hours required to become a LCPC in the State of Kansas. My supervisor can be reached at the following address if any questions arise:

Amber Johnson, LCPC RPT-S
6701 W. 64th St, Suite 109
Overland Park, KS 66202
(913) 343-5713
amber@creativeconnectionskc.com

Ethical Guidelines: I abide by the ethical guidelines of the American Counseling Association. A copy of the ACA Code of Ethics can be obtained at the following address:

American Counseling Association
www.counseling.org

ABOUT THE COUNSELING PROCESS

Counseling Approach/Theory: My approach to counseling is informed by several, complimentary schools of thought, including attachment theory and systems theory. Both theories emphasize the influence of one's family of origin on subsequent mental health. These theories also agree that individuals adapt to their environment, for better or for worse, to meet their own needs and/or the needs of the family. Greater detail of my theoretical approach will be provided upon request.

In addition to my theoretical orientation, I practice Somatic Experiencing®, a body-oriented therapy developed by Peter Levine. His method posits that individuals experience symptoms when they are unable to complete self-protective, survival responses (e.g., fight, flight, freeze) in the presence of perceived threat. As a result of these incomplete responses, individuals unconsciously replay their past in everyday life. Through mindful attention to bodily sensation, memory, behavior, emotion, and meaning, Somatic Experiencing® seeks to gently expand one's window of tolerance and release thwarted survival energy associated with unpleasant symptoms.

Voluntary Participation: Your participation in therapy is completely voluntary. If you decide to terminate the counseling relationship prematurely, please provide notice two (2) sessions in advance. I will discuss with you potential consequences of early termination and provide appropriate referrals or alternatives to counseling.

Benefits and Risks: Any time individuals seek therapy to work on difficulties within themselves or in their personal relationships, there are potential benefits and risks. Benefits may include the ability to handle specific concerns and/or interpersonal relationships in a healthier way. Clients may also gain a greater understanding of personal, interpersonal, or family issues. This new understanding may lead to greater maturity and happiness as an individual or family. There may also be other benefits that come as clients work at resolving specific concerns.

Therapy can also be challenging and uncomfortable. Reviewing and resolving unpleasant issues may result in intense feelings of anxiety, anger, depression, or frustration. As clients work to resolve personal issues or issues between family members, peers or other persons, they may experience discomfort and an increase in conflict. Changes in relationships that were not originally intended may also result.

I will discuss with each individual the benefits and risks involved in their specific situation. Clients are encouraged to discuss with me concerns they may experience at any time.

No Guarantees: Although it is my sincere hope that you find help and healing through our counseling relationship, I cannot guarantee a successful outcome. Success in counseling may be defined in various ways and influenced by many variables, some within our control and others not. Counseling may not be appropriate or effective for all.

Length of Therapy and Termination: Therapy will begin following our intake interview and last for a period of time collaboratively determined by you, the client, and me, the therapist. The duration of therapy is flexible depending upon your diagnosis (if applicable), the intensity of symptoms, and your need for continued services.

Interruptions in Therapy by Therapist: On occasion, there will be planned and unplanned interruptions in the therapeutic process. Planned interruptions may include vacations and professional development. A month's notice will be given to you in advance of such interruptions. Unplanned interruptions may include family or medical emergencies and hospitalization. If I am unable to continue the counseling relationship due to incapacitation or death, my supervisor will have access to your records only for the purpose of ensuring the continuity of care.

Interruptions in Therapy by Client: Interruptions and emergencies may also occur in your life, preventing you from attending your scheduled therapy session. If such an event occurs, you may cancel or reschedule your appointment through your online client portal with at least 24 hours notice. If you must cancel within 24 hours of your appointment, please call or email me. See **Cancellation Policy** for more details. Grace will be extended to the first missed appointment or cancellation without 24 hour notice, but a $40 fee will be charged to your account for subsequent missed appointments. This fee must be paid out-of-pocket, as insurance companies do not cover missed appointment fees.

Counselor Involvement: I am committed to providing a safe environment conducive for therapeutic work. Sessions will be started on-time and adequately prepared for. Each therapy session lasts for 50 minutes, allowing me the remaining 10 minutes to record notes for upcoming sessions. Please call me if you anticipate being late for your appointment. Out of respect for other clients, your session will end on-time and payment of the full fee is expected.

It is also important to note that, unfortunately, I cannot always be available in the event of an emergency or mental health crisis. Calling me, as opposed to emailing, is the best means of communicating an emergency. In such circumstances, I will do my best to accommodate you either in-person or over the phone, according to my availability. On occasion you may experience a time when speaking to me briefly outside a session would be helpful. As I receive notice of your need and am able to respond, I can provide, at most, two ten-minute phone crisis sessions per week without charge. Phone calls lasting 15 minutes or more will be billed in 15 minute increments at my standard hourly fee. ***If you are unable to reach me in an emergency, please call 911 or report to the closest emergency room***.

Client Involvement: You are encouraged to be actively engaged in the therapeutic process, as much as you are able. This includes, but is not limited to, setting goals, arriving to sessions on-time, providing feedback, and earnestly desiring growth and healing. We will work collaboratively to establish and maintain our therapeutic relationship, as well as create a plan of action to achieve your treatment goals. Along with the quality of our therapeutic relationship, your active participation in therapy is a key predictor of success.

Minor Clients: I serve a variety of individuals, including minors age 15 or above, however, minors are unable to consent to counseling services. I will provide age appropriate counseling information to potential minor-clients, but ultimately consent is required from the minor's parent or guardian before therapy can begin.

RIGHTS AND RESPONSIBILITIES OF THE CLIENT

Confidentiality and Privilege: Confidentiality is an important aspect of a successful counseling relationship. Confidentiality ensures that the information you share with me will be kept private and will not be disclosed to third parties without your prior written consent. You may rest assured that your records are being kept, handled, and monitored in the most professional way possible.

Exceptions of Confidentiality and Privilege: There are several exceptions to confidentiality in the State of Kansas. I may be required to disclose confidential information in the following circumstances:

- If you are a danger to yourself or others
- If you require an evaluation for involuntary commitment
- If I have reason to suspect abuse, neglect, or exploitation of a child, or an aged or incapacitated adult
- If you accuse me of wrongful conduct, I have a right to use your confidential records to defend myself
- If I am issued a subpoena that demands your records be made available for court proceedings

- If third party payers require your information for reimbursement
- If I become incapacitated or die, a personal representative would have access to your records to ensure continuity of care
- If a medical emergency should arise
- If you are a minor, your parents have a right to a reasonable account of your therapy. You may wish for this information to remain confidential. I will do my best to honor your request, unless it involves dangerous behavior, such as drug/alcohol use, risky sexual behavior, suicidal ideation, or running away.

If I am away from my office, I may use a cell phone to communicate with you. I cannot guarantee the absolute security of these calls. Please **initial** one of the following statements:

_____I **authorize** phone calls via cell phone

_____I **do not** authorize phone calls via cell phone

Release of Information: The content of your health record belongs to you. All requests for the release of records must be made in writing with two (2) weeks' advanced notice. Release forms can be obtained upon request. I will do my best to honor any request you make for your client record. If I believe that releasing your record would be harmful to you, I will discuss my concerns with you in session.

On occasion, I may be asked to fax or email information regarding your treatment. This request could be made by an insurance company or another health care provider. Please **initial** one of the following statements:

_____I **authorize** the fax or email transmission of information from my record

_____I **do not** authorize the fax or email transmission of information from my record

Privacy Notice: Please read the Privacy Notice, which is mandated by federal law and the Health Insurance Portability and Accountability Act (HIPAA), and **initial** here _____. The notice explains HIPAA and how it applies to your personal health information. By initialing above, you acknowledge that you have received a copy of the Privacy Notice.

Cancellation Policy: I understand that life circumstances are often unpredictable and may require you to cancel your scheduled session. Out of respect for other clients and myself, please be sure to cancel or reschedule your appointment at least 24 hours in advance. You may do so online through your client portal. Late cancellations must be communicated via phone or email. Emergency cancellations will be reviewed on a case-by-case basis. The second missed appointment or cancelation without 24 hours' notice will be charged a $40 fee. This fee must be paid before your next session. Please remember that insurance does not cover cancellation fees.

Fees and Charges: Each counseling session is 50 minutes in duration. A payment of **$80** must be paid prior to services rendered **(initial)**_____. Cash, credit card, and checks are acceptable means of payment, however, a 3% administrative fee is added to credit card payments. Bounced checks will be issued a $15 fee. You may refer to the **Responsibility for Payment** section for more information regarding late payment.

Court Fees: Should it be requested or required that I appear in court, there will be a $250 court appearance fee, as well as an $80 hourly fee assessed for my time. Additional fees may apply for copying files or report writing.

Insurance Reimbursement: At this time, I am not a provider on any insurance panels. If you would like to use out-of-network benefits, I will gladly supply you with an invoice that can be used to submit a claim to your insurance company. Please be advised that some, but not all, insurance companies will reimburse a portion of counseling fees. I cannot guarantee that your insurance company will do so. You are responsible for knowing your insurance benefits. As mentioned previously, missed appointment fees are not covered by insurance.

Responsibility for Payment: You are ultimately responsible for the full payment of your counseling sessions. Once two (2) payments are missed, a $20 late fee will be issued to your account and counseling services will be suspended until full payment is made. Please discuss your inability to pay for services with me.

Counseling and Financial Records: An electronic file has been created in your name to maintain the organization of your counseling records. I keep concise records, noting only that you were present, the interventions I used, and the topics we discussed. In order to uphold the standards of the State of Kansas, your records will be maintained using a HIPAA compliant, electronic medical records software. Your file will be stored five (5) years after our last professional contact, at which time the contents of your file will be disposed of.

Disputes and Complaints: As with all my clients, I hope you are satisfied with your counseling experience. Your feedback is much appreciated and will help me provide the best services possible. In the unfortunate case of a conflict or complaint, please discuss this matter with me personally. If the issue cannot be resolved between us, my supervisor, Amber Johnson, LCPC RPT-S, is also available to speak with you. If, after speaking with me and my supervisor, the issue remains unresolved, you may file a complaint with the Kansas Behavioral Sciences Regulatory Board at the following address:

Kansas Behavioral Sciences Regulatory Board
700 SW Harrison St, Suite 420
Topeka, KS 66603
(785) 296-3240
www.ksbsrb.ks.gov

RESPONSIBILITIES OF THE COUNSELOR

Affiliation Relationship: I am contracted to provide counseling services through Lifeline Counseling Center of Olathe, KS.

Colleague Consultation: To provide the highest possible quality of care, I may occasionally discuss your case with trusted colleagues in the counseling profession. Your confidentiality will be upheld to the best of my ability and only information necessary for your care will be disclosed.

Tape Recording or Videotaping Sessions: For the purposes of professional growth and development, my supervisor may request that I record one or more of our counseling sessions to provide me with feedback. The recording equipment, either audio or video, will be aimed toward me to protect your confidentiality. If my supervisor makes a request, I will gather your consent in writing before the recording is implemented. Please be aware that you have a right to refuse a request for recording with no negative consequences to you. If you consent to the recording you are also free to withdraw your consent at any time during the process. Recordings will be labelled with my name and the date only. Your name will never be displayed on a recording. As with all other counseling records, any recording will be secured appropriately in my office. After 5 years, the media will be destroyed or taped over.

Dual Relationships: Your experience of therapy may produce an array of emotions and feel personally close, but keep in mind that that the therapeutic relationship is a professional one, as opposed to personal or social. Due to the nature of our relationship, and for your well-being and confidentiality, I do not meet clients outside the office. If I see you in public I will not approach you or address you in anyway, but greet you briefly if you choose to approach me. If I am invited to a formal ceremony (e.g., graduation, wedding), I will weigh the benefits and the risks to you as a client and act accordingly. No information disclosed in session will be discussed outside my office, nor will I give any indication that I am your therapist.

CLOSING STATEMENT

I, _____(print name), have read and understood the information provided in this Informed Consent document. I have been given the opportunity to discuss any questions or concerns I have with my therapist. My signature below demonstrates that I accept the terms stated above and voluntarily choose to enter into a counseling relationship.

Client Signature: _____ **Date**: _____

Parent/Guardian's Signature: _____ **Date**: _____

I have discussed and explained the above information with the client:

Counselor's Signature: _____ **Date**: _____