

**INFORMED CONSENT – SERVICES AGREEMENT**

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I LOOK FORWARD TO OUR WORK TOGETHER! THIS FORM CONTAINS IMPORTANT INFORMATION ABOUT MY POLICIES AND SERVICES...

**IN AN EMERGENCY** – DUE TO THE NATURE OF MY WORK, I MAY NOT BE ACCESSIBLE BY PHONE. I CHECK MESSAGES AT LEAST ONCE A DAY AND WILL TRY TO RESPOND TO YOU WITHIN ONE BUSINESS DAY. ON VOICE MESSAGE, LEAVE YOUR FIRST AND LAST NAME AND NUMBERS UP FRONT IN CASE YOU GET CUT OFF – IF YOU’LL BE DIFFICULT TO REACH, LEAVE TIMES WHEN YOU’LL BE AVAILABLE.

IF YOU FEEL YOU’LL REQUIRE HOSPITALIZATION CONTACT YOUR PSYCHIATRIST, FAMILY PHYSICIAN, OR THE NEAREST EMERGENCY ROOM AND ASK FOR THE MENTAL HEALTH PROVIDER ON CALL. IN A LIFE-THREATENING EMERGENCY, CALL 911 TO REQUEST THE POLICE AND/OR AN AMBULANCE. WHEN I’LL BE UNAVAILABLE FOR AN EXTENDED TIME, I WILL PROVIDE YOU WITH A REFERRAL OR ALTERNATE CONTACT INFO.

PLEASE SEE PAGE TWO OF THIS DOCUMENT FOR THE FULL DISCLOSURE OF **HIPAA – THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996**, THE FEDERAL LAW THAT PROVIDES PRIVACY PROTECTIONS AND PATIENT RIGHTS WITH REGARD TO THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION – PHI – USED FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. CONGRESS CALLED ON THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ISSUE THESE PATIENT **PRIVACY PRACTICES**. THESE PROTECTIONS ARE PART OF HIPAA. HIPAA REQUIRES THAT I PROVIDE YOU WITH A NOTICE OF PRIVACY PRACTICES FOR USE AND DISCLOSURE OF PHI FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

THE NOTICE, WHICH IS ATTACHED TO THIS AGREEMENT, EXPLAINS HIPAA AND ITS APPLICATION TO YOUR PERSONAL HEALTH INFORMATION IN GREATER DETAIL. THE LAW REQUIRES THAT I OBTAIN YOUR SIGNATURE ACKNOWLEDGING THAT I HAVE PROVIDED YOU WITH THIS INFORMATION BY THE END OF YOUR FIRST SESSION. ALTHOUGH THESE DOCUMENTS ARE LONG AND SOMETIMES COMPLEX, IT IS VERY IMPORTANT THAT YOU READ THEM CAREFULLY BEFORE THE SESSION. WE CAN DISCUSS ANY QUESTIONS YOU HAVE ABOUT THEM AT THAT TIME. WHEN YOU SIGN THIS DOCUMENT, IT WILL ALSO REPRESENT AN AGREEMENT BETWEEN US. YOU MAY REVOKE THIS AGREEMENT IN WRITING AT ANY TIME. THAT REVOCATION WILL BE BINDING ON ME UNLESS I HAVE TAKEN ACTION IN RELIANCE UPON IT; IF THERE ARE OBLIGATIONS IMPOSED ON ME BY YOUR HEALTH INSURER IN ORDER TO PROCESS OR SUBSTANTIATE CLAIMS ALREADY MADE UNDER YOUR POLICY; OR IF YOU HAVE NOT SATISFIED ANY FINANCIAL OBLIGATIONS ALREADY INCURRED BY YOU.

I ADHERE TO STRICT CONFIDENTIALITY GUIDELINES SET BY NATIONAL AND STATE ETHICAL CODES/GUIDELINES. ALL CONVERSATIONS BOTH BY TELEPHONE AND IN PERSON ARE CONFIDENTIAL TO THE EXTENT OF MY CONTROL. COMMUNICATIONS WILL BE MADE BY PHONE AND/OR EMAIL (UNLESS OTHERWISE INSTRUCTED). INDIVIDUAL RECORDS SHALL BE KEPT CONFIDENTIAL, EXCEPT AS NOTED IN THE NOTICE OF PRIVACY PRACTICES, AND: WHEN NEED ARISES TO DISCUSS CASE MATERIAL FOR THE PURPOSE OF PEER CONSULTATION OR TREATMENT PLANNING; OR WHEN THE CLIENT HAS GIVEN CONSENT TO SHARE SPECIFIED INFORMATION WITH IDENTIFIED PERSON(S). ANY ADDITIONAL INFORMATION SHARING WOULD REQUIRE A RELEASE SIGNED BY THE CLIENT.

**ADDITIONAL INFORMATION**

- A. INDIVIDUAL COUNSELING/COACHING SESSIONS ARE AN HOUR IN LENGTH; DEEPER CORE ISSUE EMDR PROCESSING AND ENERGY MEDICINE SESSIONS ARE USUALLY 90-MINUTES MINIMUM. THE NUMBER OF SESSIONS WILL BE DETERMINED UPON INTAKE AND REVIEWED AS NEEDED.
- B. HOLISTIC WELLNESS SESSION/S MAY/MAY NOT INVOLVE CLINICAL THERAPY ISSUES. A TYPICAL INTAKE MAY TAKE 1-3 SESSIONS DEPENDING ON THE LEVEL OF THERAPEUTIC ISSUES INVOLVED. THIS IS DONE TO CLARIFY ISSUES, DEVELOP A PLAN, CONFIRM WORKING RELATIONSHIP, AND TO INSURE A FULL ASSESSMENT OF STRENGTHS AND POTENTIAL BLOCKS TO HEALING AND GROWTH.
- C. **THE INTAKE SESSION (OR UPDATE – WHEN NO SESSIONS ARE HELD FOR 6-MONTHS OR MORE) IS 90-MINUTES AND THE FEE IS \$225.00. FOLLOW-UP (ONE-HOUR) SESSION/S AND EMDR/EM SESSION/S ARE \$150.00.** LONGER SESSIONS MAY BE PRO-RATED AT \$50.00 PER 20 MINUTES - 1/2 HOUR. **BACH SESSIONS ARE 2-HRS, \$225.00 AND INCLUDE REMEDY AND INFO SHEET.**
- D. ANOTHER OPTION, 2 1-HOUR (OR 4 HALF-HOUR) PHONE COACHING SESSIONS PER/MONTH = **\$300.00**  
THE FEE IS REDUCED IF PRE-PAYING: **3 MONTHS (6 SESSIONS @ \$250. PER/MO) = \$750.00** INSTEAD OF \$900.00  
**6 MONTHS (12 SESSIONS @ \$200. PER/MO) = \$1,200.00** INSTEAD OF \$1,800.00,
- E. BASED UPON INDIVIDUALIZED NEEDS YOU MAY BE REFERRED TO SEE ANOTHER HEALTH CARE PROFESSIONAL FOR AN ADDITIONAL EVALUATION, CONSULTATION, OR ONGOING CARE.
- F. ALWAYS GO TO HOSPITAL ER, GET PSYCHIATRIC CARE, OR CALL 911 FOR EMERGENCY SUPPORT, WITH FEELINGS OF SUICIDALITY, OR THOUGHTS OF DOING HARM TO SELF OR OTHERS.
- G. **MINORS & THEIR PARENTS**— PATIENTS UNDER 18 YEARS OF AGE (WHO ARE NOT EMANCIPATED) AND THEIR PARENTS SHOULD BE AWARE THAT THE LAW ALLOWS PARENTS TO EXAMINE THEIR CHILD’S TREATMENT RECORDS \*UNLESS I BELIEVE THAT DOING SO WOULD ENDANGER THE MINOR CLIENT IN WHICH CASE, I WILL NOTIFY THE PARENTS. BECAUSE PRIVACY IN PSYCHOTHERAPY IS ESPECIALLY CRUCIAL TO SUCCESSFUL PROGRESS WITH TEENAGERS, IT IS MY POLICY TO REQUIRE AN AGREEMENT FROM PARENTS THAT THEY CONSENT TO GIVE UP THEIR ACCESS TO THOSE RECORDS. I WILL PROVIDE GENERAL INFORMATION ABOUT THE PROGRESS OF A TEEN’S TREATMENT/ATTENDANCE AT SCHEDULED SESSIONS. I’LL PROVIDE PARENTS WITH A SUMMARY OF THE TREATMENT WHEN COMPLETE, OR AS AGREED. ANY OTHER COMMUNICATION WILL REQUIRE THE TEEN’S AUTHORIZATION, UNLESS I FEEL THAT THAT S/HE IS A DANGER TO SELF OR IS A DANGER TO SOMEONE ELSE. BEFORE GIVING PARENTS ANY INFORMATION, I’LL DISCUSS THE MATTER WITH THE MINOR CLIENT IF POSSIBLE, AND DO MY BEST TO HANDLE ANY OBJECTIONS HE/SHE MAY HAVE.

**RIGHTS AND RESPONSIBILITIES**

- A. YOU HAVE A RIGHT TO CONFIDENTIALITY WITHIN THE LIMITATIONS DESCRIBED ABOVE AND IN THE HIPAA NOTICE (PAGE 2).
- B. YOU HAVE THE RIGHT TO BE INVOLVED IN YOUR GOAL SETTING/TREATMENT PLANNING PROCESS/LENGTH, FREQUENCY.
- C. YOU HAVE THE RIGHT TO BE INFORMED OF ANY POTENTIAL BENEFITS OR RISKS ASSOCIATED WITH YOUR TREATMENT. IT IS FOR INSTANCE, NORMAL FOR SYMPTOMS TO INTENSIFY BEFORE THEY ARE REDUCED.
- D. YOU HAVE THE RIGHT TO REFUSE TREATMENT, AND TO RECEIVE TREATMENT FROM COMPETENT HEALTH CARE PROFESSIONALS WHO RESPECT YOUR INDIVIDUALIZED NEEDS – OR TO REQUEST A REFERRAL TO AN OUTSIDE PROFESSIONAL.
- E. A RELEASE IS REQUIRED IN COUPLES & FAMILY COUNSELING FOR THE COUNSELOR(S) TO DETERMINE HOW INFORMATION MAY BE SHARED FROM INDIVIDUAL SESSIONS IN COUPLE’S SESSIONS, AND/OR TO COORDINATE GOALS/TREATMENT.
- F. FOR CLIENTS 18 YEARS OF AGE OR OLDER, ACCESS TO RECORDS/TREATMENT INFORMATION IS AVAILABLE.
- G. **CALL TO CANCEL/RESCHEDULE ASAP, IF YOU’LL NEED TO MISS A SESSION (MINIMUM, 24 HOURS NOTICE).** I WILL ALSO GIVE THE SAME NOTICE BARRING EMERGENCY/ILLNESS. MISSED PRE-PAID APPOINTMENTS CAN’T BE MADE UP. IF YOU DON’T SHOW FOR A SESSION (OR GIVE LESS THAN 24 HOURS NOTICE, OR CAN’T RE-SCHEDULE WITHIN A WEEK OR SO) THE FULL SESSION FEE WILL APPLY BARRING CIRCUMSTANCES THAT WE BOTH AGREE WERE BEYOND YOUR CONTROL, I.E., ILLNESS, OR EMERGENCY.

I have read and understand the above statements, and I have had the opportunity to ask questions about the statements above and the Notice of Privacy Practices. I’ve been provided with a copy of this Informed Consent, emergency contact information and the Notice of Privacy Practices.

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CLIENT SIGNATURE

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DATE