**Client Rights and Informed Consent**

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Welcome to Daybreak Counseling. This document contains important information about the professional services and business policies you can expect to receive. Please read over the information carefully, and feel free to discuss any questions or concerns with your clinician during your initial session.

**Counseling Services**

**1. You have the right to treatment, regardless of race/ethnicity, religion, gender, sexual orientation, age, or disability.**

The purpose of meeting with a counselor or therapist is to gain help with problem areas in your life, which are keeping you from being successful in other areas. There are many different methods your counselor may use. In order for your counseling to be most successful, you will have to work on things you and your clinician talk about both during sessions and at home.

**2. You have the right to determine who will provide treatment for you. You also have the right to deny counseling.**

Counseling can provide many benefits such as better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. Since therapy often involves discussing unpleasant aspects of your life, there exists the possibility that you may also experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.

**3. You have the right to terminate counseling at any point without question or penalty.**

If for any reason you are thinking of, or desiring to, terminate your counseling sessions, it is asked that you speak with your clinician beforehand so that he or she may determine the appropriate course of action and/or assist you in finding alternate services.

**Confidentiality**

**4. You have the right to have the information you share remain confidential.**

In general, the privacy of all communications between a client and a therapist is protected by law. Information about your counseling can only be released to others with your written permission.

**The following are legal exceptions to your right to confidentiality. Your clinician will inform you of any time he or she believes he or she will have to put these into effect:**

**a.** If the counselor has good reason to believe you will harm another person, he or she must attempt to inform that person and warn them of your intentions. He or she must also contact the police and ask them to protect the intended victim.

**b**. If the counselor has good reason to believe you are in imminent danger of harming yourself, he or she may legally break confidentiality, and call the police or the county crisis team.

**c.** If the counselor is court subpoenaed for any reason, he or she may be required by law to provide documentation of your therapy sessions to the requesting judge.

**d.** If the counselor has reason to believe that you are abusing or neglecting a child or elderly adult, or if you provide information about someone engaging in such behavior, he or she must immediately inform Child Protective Services and/or Adult Protective Services within 48 hours.

**e**. The counselor will occasionally consult with a clinical supervisor to ensure that you are getting the best possible care.

**Appointments**

**5. You have the right to receive individualized treatment, including a verbal discussion of your treatment plans and goals, and to ask questions at any time about the therapeutic process and interventions used in your sessions.**

Your clinician will normally conduct an evaluation that will last from 1 to 2 sessions, at which point you can decide if Daybreak Counseling Service is the best practice to provide the services you need. If counseling has begun, one 45-55 minute session per week will be conducted unless it is determined that more or fewer sessions are required. You must provide 24-hours advance notice of cancellation, unless agreed otherwise. At that point, attempts will be made to reschedule the appointment. If you are late for a session, it will end at the regularly scheduled time. **If you should miss 2 sessions without canceling or with less than 24 hours’ notice, you will be responsible for paying a $35.00 missed session fee at the next scheduled meeting.** *If you fail to show for two or more consecutive sessions and do not respond to attempts to reschedule, it will be assumed that you have terminated counseling and your file will be closed.*

**Professional Fees**

**6. You have the right to know the cost of the services Daybreak offers you.**

Daybreak Counseling is a not-for-profit organization. A sliding scale, based on household size and income, is used to determine session fees. Fees range from $40 to $70 per 45-55-minute session. Your therapist will review your fee at the beginning of your counseling relationship.

**Billing and Payments**

**7. You have the right to understand how you will be billed.**

You will be expected to pay for each session at the time it is held unless other arrangements are agreed upon prior to your session, or unless you have insurance coverage. In circumstances of unusual financial hardship, we may negotiate a fee adjustment or payment installment plan with you.

**Insurance Reimbursement**

**8. You have the right to know how your insurance coverage may or may not impact the number of sessions you receive.**

It is very important that you find out exactly what mental health services your insurance policy covers. “Managed Health Care” plans such as HMOs and PPOs often require authorization before providing reimbursement for mental health services. Some do not allow services to be provided once your benefits end. Some insurance companies may require you to authorize us to provide them with a clinical diagnosis, which can include providing clinical information such as treatment plans or summaries. Your clinician will provide you with a copy of any report he or she submits, if requested.

**Contacting Us**

**9. You have the right to know when and how your counselor may be reached outside of your session**

Your counselor will not answer the phone while meeting with another client. When unavailable, it is advisable to leave a voicemail message. Your counselor will make every effort to return your call on the same day, with the exception of weekends and holidays. If your clinician will be unavailable for an extended time, he or she will provide you with the name of a colleague to contact. If it is an emergency, and you are unable to reach your counselor, please contact mobile crisis or the nearest hospital Emergency Room.

**Electronic Communications**

**10. You have the right to receive notice about the limits of electronic communication outside of your scheduled face-to-face sessions.**

**Email Communications and Text Messaging**

Email exchanges with your counselor should be limited to information such as setting and changing of appointments, billing matters, and other related issues. Email regarding session-related content is not appropriate. Text messaging will only be acceptable in cases of appointment rescheduling or cancellation.

**Social Media**Counselors will not communicate with clients through social media platforms like Twitter and Facebook. In addition, if your counselor discovers that he or she has accidentally established an online relationship with you, your clinician will cancel that connection, as these types of casual social contacts can create significant security risks for you, and potentially compromise the therapeutic relationship.  
**Websites**Our program website is easily accessible and is only used for professional reasons to provide information to others about clinicians and the practice. Any questions you have about Daybreak as an organization should be discussed during your counseling sessions.  
**Web Searches**Your counselor will not use web searches to gather information about you without your permission, as this violates your privacy rights. However, you might choose to gather information about your clinician in this way. Please be aware that any information gathered outside of our program website may or may not be accurate. Therefore, please come prepared to discuss any information received in this manner with your clinician during your session so that any concerns or issues may be properly addressed.

**Professional Records**

**11. You have the right to request a written copy of your session records.**

As a counseling client you have the right to request a copy of your records. It is recommended that you review them in the presence of your clinician so that their contents can be discussed. Counseling laws and standards require that treatment records be maintained for five years following the termination of a case.

**12. You have the right to receive a written statement of your rights.**

A copy of the client rights and responsibilities, as well as the informed consent, shall be provided to you prior to the first session which you may keep for your records.

**Informed Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the “Client Rights and Responsibilities,” and have asked any questions that have arisen from my reading of the statement.

I understand the risks and benefits associated with beginning counseling and that I may stop at any time without question or penalty, so long as I have previously paid in full for any services rendered.

I understand that my identity will be protected unless confidentiality must be breached for the reasons stated in the “Client Rights and Responsibilities.”

I understand the fees that I am responsible for paying and the timeframe for doing so.

My signature below attests to my having read and understood all of the above information. Moreover, my signature indicates my agreement to become a client of Daybreak Counseling Services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature (parent/guardian if under 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinician Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date