Client Name:_____ DOB:_____

INFORMED CONSENT

Thank you for choosing Spaulding Counseling Services, LLC. Michael Spaulding and Sarah Spaulding are both Licensed Clinical Professional Counselors (LCPCs). Typically, the initial appointment will take approximately 50-60 minutes to become familiar with each other, identify the issues you desire assistance with, and discuss preliminary goals. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, state and federal laws and your rights as a consumer. If you have any questions or concerns, please ask and we will try to provide you with all the information you need.

Our practice is located at 9881 Broken Land Parkway Suite 105 Columbia, Maryland 21046. The practice is currently limited to Tuesday and Thursday hours.

Michael Spaulding can be reached on his cell phone at (410)599-7870.

Sarah Spaulding can be reached on her cell phone at (410)599-7973.

Spaulding Counseling Services is an independent practice sharing a group suite with other practitioners. Practicing in Suite 105 does not imply a joint group practice, a single legal professional entity or employer/employee relationship. All practitioners here maintain separate practice policies that are not subject to any rules or restrictions by any other practice here. Any client/patient entering into treatment with any of the providers in suite 105 are clients/patients of that practitioner and that practitioner's practice only. All fee-related policies/procedures, including but not limited to insurance arrangements for treatment, evaluation, consultation or otherwise are the domain of the individual practitioner and must be addressed, arranged and determined by and between each practitioner and client/patient. The practices of all providers are separate and independent such that no party has control, authority or liability over the nature, type and function of the other party's practice. No party is responsible for the actions, treatment decisions, practice procedures or debts of any other party. All parties are licensed and insured. They function as separate practices, separately licensed and insured.

Emergency Situations:

Should an emergency arise outside of normal business hours, you are advised to call 911 or go immediately to the nearest emergency room.

Fee Schedule and Policies:

Intake Assessment and Interview	$135
Family / Couples Counseling	$135 / 60 minute session
Individual therapy	$100 / 50 minute session
Hypnotherapy Session	$100 / 50 minute session
Bounced check fee	$25

If you need to cancel an appointment, kindly do so within 24 hours of the appointment time. Otherwise, 50% of the appointment fee will be charged before a new appointment can be made.

Payment will be collected at the time of service. Cash or check made payable to Spaulding Counseling Services is accepted.

Spaulding Counseling Services, LLC does not participate in any managed health care companies. If desired, a copy of the services being provided will be made available to you to submit to your insurance provider for out of network reimbursement.

Client Bill of Rights:

1. To be treated with consideration, respect, and full recognition of the client's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Not be physically or mentally abused by any staff;
4. Be free from discrimination;
5. Be free from restraints;
6. Privacy and confidentiality; and
7. Not participate in any experimental research unless fully informed and with written consent

Confidentiality:

Patient confidentiality is protected by Federal Laws and Regulations. Generally, the program will not say to any person outside of the program that a patient attends the program. Verbal communications, clinical records, and/or psychotherapy notes will remain confidential except in the following circumstances:

1. The patient consents in writing by signing a release of information
2. The disclosure is required by law or allowed by court order
3. Mandated reporting requires disclosure of physical or sexual abuse of children
4. Threats of suicide or homicide

Violation of Federal law and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities.

In the event that Spaulding Counseling Services needs to contact you, please provide your preference of how you wish to be contacted. May we contact you by:

Home Phone (Yes / No) – If yes: _____

Cell Phone (Yes / No) – If Yes: _____

E-mail (Yes / No) – If Yes: _____

Mail (Yes / No) – If Yes: _____

_____

If you decline these options, please indicate in the space provided how you wish to be contacted:

_____

I have reviewed and understand these rights and confidentiality policies.

_____ _____

Client Signature Date

_____ _____ _____ _____

Parent/Guardian Signature Date Witness Signature Date

Primary Care Physician (PCP) and/or Psychiatrist Notification:

It may be helpful to notify your doctor of any mental health and/or substance abuse treatment so that your doctor can let us know of any possible medical issues that may affect treatment. Most insurance companies also request that therapists notify Primary Care Physicians about mental health and/or substance abuse treatment.

Please check the appropriate box below. By checking the "Yes" box and by signing this form, you will authorize Spaulding Counseling Services, LLC to notify your Primary Care Physician and/or your Psychiatrist.

[ ] NO, I would not like Spaulding Counseling Services to notify my PCP and/or Psychiatrist

[ ] YES, I would like Spaulding Counseling Services to notify my PCP and/or Psychiatrist

(If you check Yes, please fill out the remained of this form)

I give permission for Spaulding Counseling Services to notify my PCP that

_____ is being seen by Spaulding Counseling Services. I understand that a copy of this letter may be placed in my chart and I encourage my doctor to discuss my treatment with me.

Doctor's Name: _____

Address: _____

_____

Phone Number:_____ Fax:_____

Client Signature:_____ **Date**:_____

Parent/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

This area is for the office to complete:

_____ Is being seen and treated for _____

_____

_____.

If you have any questions, comments, or concerns please contact Sarah Spaulding by phone at (410)599-7873 or e-mail sarah@spauldingcounselingservices.com . Michael Spaulding can be reached at (410)599-7870 or by e-mail at Michael@spauldingcounselingservices.com.

Sincerely,

Spaulding Counseling Services

Voluntary Consent to Participate:

The client voluntarily consents to participate in therapeutic services provided by Spaulding Counseling Services. Methods used in this program may include, where appropriate, psychotherapy, counseling, couples counseling, hypnotherapy, guided imagery, relaxation techniques, Neuro-Linguistic Programming, and psychological diagnosis. All such processes are hereafter referred to as "services." The client agrees to be an active participant in the therapeutic process and share responsibility for the process and results. You agree to inform your therapist of any changes in your circumstances or medical status that may affect your ability to fully participate in the services.

The Practitioner agrees to render ethical, competent services to the best of his/her abilities and within the limits of their professional knowledge and training. However, the client understands that the Practitioner's services are not based on an exact science and that individual results may vary. The client understands that there are no guarantees as to the results or outcomes. The client remains ultimately responsible for his/ her own choices, decisions, actions, and emotions during and after participation in the program.

The client understands and acknowledges that the services to be rendered may consist of a variety of processes to include interviewing and assessment with the use of questions, visualizations, breathing exercises, role-playing, eye movement instructions, take home assignments, and physical movements. Procedures will be explained to the client in advance and will be conducted only with the client's consent. The client has the right to ask questions and address any concerns before, during, and following these processes. The client has the right to refuse to participate in any process at any time. The client has the right to reject instructions, advice, interpretations, or suggestions made by the practitioner at any time. The client understands that noncompliance with program instructions may reduce the probability of success.

Limits of Hypnotherapy / Clinical Hypnosis:

The client understands and acknowledges the following: hypnotherapy or clinical hypnosis, like any form of counseling or psychotherapy, is not an exact science. A hypnotherapist has no unusual powers or abilities, but rather attempts to communicate so as to facilitate the client's ability to think in a focused manner. The Practitioner makes no claims or guarantees to the success of the hypnotherapy / clinical hypnosis methods, whether the client will experience trance, or the degree of the trance that the client will experience. There are a number of different methods for conducting hypnotherapy and some methods may be more effective than others with a particular individual. Finding the most helpful method may involve a trial and error process. Individuals vary as to suggestibility and hypnotizability, and results can be influenced by many factors including the client's personality, motivation, mood, and health.

Hypnotherapy can be relaxing, and some clients may fall asleep or think that they have fallen asleep during the process. The Practitioner will, nevertheless, continue with the hypnotherapy session, on the assumption that the Client will continue to hear and respond to suggestions and instructions, in the same way that a sleeping person at home would respond to unusual sounds at night. The client acknowledges that he / she may or may not remember everything the Practitioner says during the session.

Use of Audio Recordings:

As a service to the client, the Practitioner may make audio recordings of some program sessions, for the client's possession and use, to reinforce hypnotic approaches to the client's stated outcomes. Since such recordings include instructions for relaxation, the client agrees to not play the recordings in a moving vehicle or when operating potentially dangerous equipment. The client also agrees to not play or listen to the recordings when providing direct supervision to a small child or incapacitated adult. The client agrees that he / she will not reproduce these audio recordings or use them for commercial purposes or financial gain. Audio recordings produced by Spaulding Counseling Services, LLC are for the client's personal use. If the client allows others to listen to recordings produced by Spaulding Counseling Services LLC, then Spaulding Counseling Services, LLC is in no way responsible for outcomes or results since Spaulding Counseling Services, LLC has not entered into a service contract with any other users or listeners.

Risks:

The client acknowledges that there may be a slight risk associated with the Practitioner's services. During the process, the client may experience some uncomfortable emotions or reviewed some unpleasant memories. The client may find his / her chosen outcomes difficult to implement. The client acknowledges that making personal changes in behavior, thinking, and emotions through psychotherapy, counseling, and coaching may sometimes require learning by trial and error and that he / she may make mistakes or experience some confusion or setbacks in the process. The client acknowledges and accepts these risks.

Signed Statement of Understanding and Consent:

The client's signature below indicates that he / she has read, understands, and accepts this agreement and enters into it freely. The client has received a copy of this document.

_____

Client signature Date

_____

Spaulding Counseling Services, LLC representative Date