Rae of Light Counseling, LLC
Janet Kartler, MA, LPC
(602) 540-6272

Consent for Treatment

Welcome to Rae of Light Counseling. Before proceeding, please read this page thoroughly. If you understand and agree to the following information regarding *Limits to Confidentiality*, *Services*, and *Fees Policy*, please initial and sign below. If you have questions, please do not sign until we have discussed the information in session. Thank you.

Limits to Confidentiality

Information regarding your ("client") counseling and mental health is protected and confidential, and will not be disclosed or released without your permission and signed release. There are exceptions to confidentiality which include the following:

1) Consulting with other counseling professionals for treatment and educational purposes (client's identifying information will be omitted)
2) Danger to harm self or others
3) Cases of child and elder abuse and neglect
4) Court order or subpoena of case records
5) Demand from the Arizona Board of Behavioral Health Examiners
6) Information required for insurance claims (including insurance provider and billing service)
7) Internet/electronic transmitting of client-counselor or other privileged information*
8) Other circumstances in which the law requires release of information

**The Internet is not a guaranteed secure means of exchanging information and may compromise confidentiality. Professional advice will not normally be provided via the Internet or other forms of electronic transmission. Sessions conducted via phone or Internet are not guaranteed secure and are not recommended but may be requested and are the assumed risk of the client.*

In the case that you ("client") are an unemancipated minor, please note that the provider may provide or deny access to client information to a parent or guardian consistent with State law in exercise of professional judgment (45 C.F.R § 146.524) and taking into consideration your ("client") request.

Initials ________

Patient Rights & Records

Patient Rights (HIPAA) provides you with several rights with regard to your Clinical Record and disclosures of Protected Health Information (PHI). These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the locations to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, and the HIPPAA Notice Privacy Form. I am happy to discuss any of these rights with you.

Client records are retained for six (6) years after the last date an adult client received the professional services. If a client is a minor, records are retained the later of: three years after a child client's eighteenth birthday or six years after the last date of professional services. Records are stored in a secure area not accessible to anyone other than your therapist and/or a qualified designee. Records are disposed of after the stated period of retention and are shredded and/or incinerated.

If this practice is terminated or sold and this therapist is not otherwise available, please check the website at www.raeoflightcounseling.com or call the business phone (602)540-6272 for updated information on locating and accessing records.

Initials ________

Services

You have chosen to receive psychotherapy services from Janet Kartler, Licensed Professional Counselor (AZ). Improvement cannot be guaranteed. Because psychotherapy is a cooperative effort, you and your therapist must work together to address therapeutic issues. It is your right to participate in treatment decisions and the development and review of your treatment plan. You have the right to refuse any recommended treatment and to terminate therapy at any time. Please understand that, while the course of therapy is designed to be helpful, it may at times be uncomfortable.

Rae of Light Counseling is not a 24-hour crisis or emergency facility. In case of a medical or life threatening emergency call 9-1-1. For mental health emergencies or crises, call the EMPACT HelpLine (480)784-1500, which provides 24-hour crisis intervention services.

Initials ________

Fees & Insurance

Cash, check or credit card payment at the time of appointment: $150 for initial appointment,
$130 for 50 min standard appointment, and $75 per additional ½ hour (must be prearranged). Clients are responsible for all copays and deductibles in full at each visit. Services not covered by insurance shall be paid within 30 days of being billed.

Insurance payment is based on contracted rates and insurance approval for services, and is not the responsibility of the provider. Deductibles and copayments are due at the time of service. Contracted insurance remittance is relinquished to Janet Kartler, LPC for payment of services rendered. Out-of-Network (OON) insurance claims are the responsibility of the client. In the case a client is using OON benefits, sessions must be paid in full at the time of service.

Good Faith Estimate

By law, health care providers must provide patients without insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services. You have the right to receive a "Good Faith Estimate" for the total expected cost of any non-emergency healthcare services, including psychotherapy services. You may ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service. If you receive a bill that is $400 or more above what is stated on your Good Faith Estimate, you may dispute the bill. Be sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises

Cancellation Policy

Appointments reserve the predetermined time with your therapist and fees for this reservation are not contingent upon your attendance. **To cancel an appointment, 24-hour advanced notice is required. A $60 fee may be assessed to the client for sessions cancelled with less than 24-hours notice.** Consecutive or patterned late cancellations or no-shows may result in a same-day scheduling restriction.

Document Fees
A fee up to $25 may be assessed for collecting and copying or faxing your records. Additional fees may be assessed to cover shipping if documents are mailed. *Please note: Rae of Light Counseling cannot release copies of documents received from another clinician or facility*. A fee up to $45 may be assessed for document completion (ie, FMLA forms, victim reimbursement applications). These fees are separate from fees for treatment. These fees are not covered by insurance and are the responsibility of the client.

Initials _______

Please circle:

Yes No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.
Yes No I understand that insurance is a contract between me, my insurance company and/or employer. I authorize the release of any medical information necessary to process my insurance claims.
Yes No I authorize insurance benefits to be paid directly to Janet Kartler, LPC.
Yes No I give permission and consent for treatment.
Yes No I have received a copy of this form and privacy practices.
Yes No I have received information regarding HIPAA and Good Faith Estimates.
Yes No I understand that there may be times when Janet Kartler, LPC may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is protected during consultation. I give permission for Janet Kartler, LPC to consult as needed to provide professional services to me as a patient.

I have read the above information. I understand and agree to the terms described regarding *Limits to Confidentiality*, *Patient Rights*, *Services* and *Fees & Insurance*.

Client Signature ____ Date ____________

Parent/Guardian Signature __________________________________ Date ____________

Therapist Signature ____ Date ____________

Client Information

Name (print) ______________________________

Address ______________________ City/State/Zip ______________

Phone: Home ______________ Cell ______________ Work ______________

Preferred contact number ______________ Okay to leave a message ☐ Yes ☐ No

Email address ______________________________

Date of Birth ______________ Age ______ Education ______________

Occupation ______________ Employment status ______________

Military service ☐ Yes ☐ No Branch ______________ Dates of Service ______

Racial or ethnic heritage ______________________________

Cultural/spiritual/religious preferences ______________________________

Currently living with (ie, spouse, parents, roommates, alone) ______________

Emergency Contact ______________ Relationship ______________

Emergency contact phone 1) ______________ 2) ______________

May I contact this person in case of an emergency? ☐ Yes ☐ No

Relationships (✓ all that apply)

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other ______________

Name of spouse/partner ______________________________

Children (names/ages) ______________________________

Other supportive relationships ______________________________

Health

Significant medical conditions ______________________________

Current medication(s) ______________________________

____

Previous or current mental health diagnosis(es)____

____

Name of Prescribing Doctor ______________________________ Phone: __________________

(A Release of Information form is required if you wish for me to coordinate care.)

Prior hospitalization for: ☐ Psychiatric care?

☐ Suicide attempt?

☐ Chemical dependency?

Alcohol Use/Drug Use/Addictive Behavior

Alcohol:

Current Frequency of use ☐ Daily ☐ Weekly ☐ Monthly/less ☐ Never

Past Frequency of use ☐ Daily ☐ Weekly ☐ Monthly/less ☐ Never

Drugs:

Current Frequency of use ☐ Daily ☐ Weekly ☐ Monthly/less ☐ Never

Past Frequency of use ☐ Daily ☐ Weekly ☐ Monthly/less ☐ Never

Other addictive behavior (Please specify) ____________________

Lost work due to alcohol/drugs/other addiction? ☐ Yes ☐ No

DUI or other alcohol/drug related offense? ☐ Yes ☐ No

Family history of alcohol or drug use/abuse? ☐ Yes ☐ No

Attending AA or other 12-step program? ☐ Yes ☐ No

Current Issues & Focus (✓ all that apply)

☐ EMDR therapy

☐ Anxiety ☐ Panic ☐ Fear/worry

☐ Phobia ________________________________

☐ Esteem/confidence

☐ Sleep ☐ Concentration/focus

☐ Meaninglessness / hopelessness

☐ Weight ☐ Appetite

☐ Depression ☐ Mood changes

☐ Opposition/ impulsivity

☐ Work issues ☐ Finances

☐ School performance

☐ Suicidal thoughts ☐ Homicidal thoughts

☐ Post Traumatic Stress Disorder PTSD

☐ Grief/death

☐ Child abuse/neglect

☐ Sexual assault/molestation

☐ Trauma ________________________________

☐ Spiritual/religious distress

☐ Anger/rage

☐ Guilt/shame

Relationships:

☐ Spouse ☐ Partner

☐ Parent(s) ☐ Family ☐ Other ____________

☐ Parenting ☐ Blended family issues

☐ Dating issues/dating success

☐ Divorce ☐ Custody

☐ Trust ☐ Communication

☐ Codependence ☐ Boundaries

☐ Loneliness ☐ Isolation

Addictive behavior/ unwanted habits:

☐ Alcohol ☐ Drugs

☐ Spending ☐ Gambling

☐ Sex/pornography

☐ Internet

☐ Food ☐ Exercise

☐Obsessive thought /compulsive behavior

☐ Other issue(s) for counseling ____

Family History (✓ all that apply)

Parents: ☐ Married ☐ Divorced ☐ Separated ☐Never married

Number of siblings_________________ Birth order ________________________

☐ Adopted ☐ Foster care ☐ Other ____________________________________

Any physical, sexual or other abuse in your family? ☐ Yes ☐ No

Other abuse in your life? ☐ Yes ☐ No

Other previous or current counseling? ☐ Individual ☐ Group ☐ Hospital ☐ Drug/alcohol

☐ Religious ☐ Marriage/Pre-Marriage ☐ Family ☐ Other ________________________________

Do you have any interest in group counseling if an appropriate group becomes available?

☐ Yes ☐ No

INSURANCE INFORMATION

Please fill in all applicable areas; print clearly and carefully. Incorrect or illegible information causes significant delays. Bring with you your insurance card or a copy of both sides of your card. Thank you.

Client's Name ______________________________

Address ______________________________

City/State/Zip ______________________________

Phone: Home ______________ Cell ______________ Work ______________

Date of Birth ______________ SSN ______________

Primary Insurance

Name of Insured ______________ Insured DOB ______________

Relationship to Client ______________ Employer ______________

Insurance Company ______________________________

Insurance Address ______________________________

Insurance Phone ______________________________

Group # ______________ ID # ______________

☐ Check if this is an EAP Authorization # ______________

Secondary Insurance

Name of Insured ______________ Insured DOB ______________

Relationship to Client ______________ Employer ______________

Insurance Company ______________________________

Insurance Address ______________________________

Insurance Phone ______________________________

Group # ______________ ID # ______________

ONLINE COUNSELING CONSENT

Online therapy is conducted using interactive audio, video, email or a combination thereof. In many cases, online therapy benefits a client as well as sessions conducted in person, but results cannot be guaranteed. Online services are not appropriate for all clients and situations. If, at any point, the therapist does not recommend online therapy, every effort will be made to offer an office appointment or referral.

Security
Clients are entitled to confidentiality and best efforts will be made by the therapist to maintain this right during online therapy. However, transmitting personal information via the Internet (including email) or phone should be done with discretion, as security cannot be guaranteed.

Limitations
Online therapy is intended to provide quality information and assistance with psychological issues and present problems. It may, however, not be the best option for in-depth psychotherapy and more intensive techniques, such as EMDR for trauma.

When should I seek traditional therapy rather than online therapy?

1. If you are having thoughts of harming yourself or someone else, or psychotic symptoms (e.g., hallucinations). In the case of harm to self or others, please call **911** or **1-800-SUICIDE** (National Suicide Hotline).
2. If you are in an abusive or violent relationship.
3. If you are experiencing severe depression.
4. If you struggle with significant substance abuse dependence.

Technical Difficulties/Service Disruption
It should be understood that, when communicating by Internet or other electronic means, disruption of service or other technical difficulties are likely to occur from time to time. Sessions will be completed in the time designated, if the problem can be corrected. If it cannot be corrected, the session will be rescheduled. If a disruption occurs at the time of crisis, the patient is responsible for contacting the counselor immediately by phone at **(602) 540-6272** or dialing **911**.

By signing, I attest that:

1. I have read and understand the policies and limitations related to online counseling and agree to participate.
2. I reside in the state of Arizona.
3. I am aware of my right to withdraw consent for online therapy at any time.

______________________________ ______________
Client Signature Date

______________________________ ______________
Parent/Guardian Signature Date

______________________________ ______________
Janet Kartler, MA, LPC - Therapist Date