Spero Counseling Services, LLC
Jaimie Baecker, LMHC

INFORMED WRITTEN CONSENT FOR TREATMENT

PARTICIPATION IN PSYCHOTHERAPY TREATMENT:

Therapy is a voluntary relationship between people that works, in part, because of clearly defined rights and responsibilities. You may withdraw from treatment at any time without penalty and I, the therapist, reserve the right to terminate treatment if deemed ethically or clinically necessary. Therapy does not offer any guarantees. If at any time you become dissatisfied with what is happening in therapy I hope that you will talk about it with me so that I can respond to your concerns. If you believe that I have behaved illegally or unethically, you may file a complaint with the Florida Department of Health, Division of Medical Quality Assurance. For information on how to file a complaint, please call 1-888-419-3456 or visit www.doh.state.fl.us/mqa.

MY RESPONSIBILITIES TO YOU AS YOUR THERAPIST:

Confidentiality: I am committed to maintaining strict confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your prior written permission. I will not acknowledge you if I see you outside of the therapy room, unless you first acknowledge me. As the client, you control to whom confidential information will be disclosed. You may also revoke your permission for me to share information at any time. You may request anyone you wish to attend a therapy session with you.

When the client is a minor, both parents (regardless of marital status or custody arrangements) have the right to be informed about their child's treatment, and I will typically encourage family therapy. However, the confidences shared in individual sessions by a child or adolescent will be respected so that an effective therapeutic relationship can be established.

With regards to couple or family therapy, each of the clients present must, in writing, waive confidentiality before any records or information can be released. As well, if you and your partner or family members decide to have individual sessions *as a part* of the couple or family therapy, what you say in those individual sessions will be considered to be a part of the couple or family therapy and can be discussed in our joint sessions. I will remind you of this policy before beginning any individual sessions.

The following are legal exceptions to confidentiality mandated or implied by Florida law. I will inform you any time that I think I will have to put these into effect:

1. If I have reason to believe that you are abusing or neglecting a child, adolescent, or elder, or if you give me information about someone else that is doing this, I must inform the Department of Children and Families by calling the FL Abuse Hotline at 1-800-96-ABUSE.
2. If I have reason to believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police to have you taken to the local crisis stabilization unit. I will explore all other options with you before I take this step.
3. If I have reason to believe that you will harm another person, I may attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
4. When there is a valid court order compelling records or witness testimony. I will attempt to obtain written permission from you when possible regarding the release of these records and we can also discuss obtaining a protective order to help maintain confidentiality of records. Please let me know if you are in this kind of situation so that I can take the utmost care in protecting your privacy.

Records and Record-keeping: I keep records with a brief summary of each session (i.e., who, when, and what was discussed) called a "progress note." If your records are requested, I normally submit a summary of the record to the requesting

party. You have the right to see your record at any time. The physical record is the property of my counseling office and I will maintain your record in a locked, secure location for a minimum of 7 years, according to Florida law.

Training, credentials, and ethical regulations:

a. I have a Master of Arts in Counseling Psychology from the University of West Florida. I am a Licensed Mental Health Counselor (#MH13185) in the state of Florida. I also have specific certification in Parent-Child Interaction Therapy and Trauma-Focused Cognitive Behavioral Therapy.
b. I am a certified therapeutic riding instructor through the Professional Association of Therapeutic Horsemanship Intl. I have twelve years experience working with various populations using horsemanship and riding skills to help participants achieve physical, emotional, and cognitive improvement.
c. I use a variety of techniques in therapy, trying to find what will work best for you. I may suggest that you consult with a physical health care provider, another therapist, or participate in a therapy or support group as part of your work with me. I will provide appropriate referrals as necessary. You have the right to refuse anything that I suggest without being penalized in any way.
d. Legally and ethically, I do not engage in social or sexual relationships with clients or former clients.
e. There are times when I consult with professional colleagues to gain greater insight and feedback for my work. If I consult on my work with you, I will not use your name or any information that can identify you.

Out of the office and After-hour emergencies: If I am going to be away from the office for an extended period of time, I will tell you well in advance. I will also provide you with the name and phone number of an available therapist. If you have an emergency in between sessions or while I am out of town, you are first encouraged to call 911. The police can escort you to the crisis stabilization unit if needed. Then you may contact me and let me know where you are and how you can be reached. If you are not having an emergency, please reserve all other information for our next scheduled appointment.

YOUR RESPONSIBILITIES AS A THERAPY CLIENT:

1. You are responsible for coming to your session on time. If you are late, we will end on time and not run over into the next person's session. If you miss a session without notice, you must pay for that session at our next scheduled meeting. If this happens regularly, we will discuss how it is impacting the therapy process. The only exception to this rule is if you find yourself in an emergency situation.
2. You are responsible for making your payment at each scheduled session. Your fee is based on a 60-minute session. The cost of one session is $40.00. If you are not able to pay the full amount, and can provide evidence of hardship, then a reduced rate may be agreed upon. I accept payment in any form except cash, credit, debit, or check. There is a $25.00 fee for returned checks. <u>Please sign on the last page to acknowledge your understanding and consent to this fee agreement.</u>
3. I do not file insurance and I am not a member of any HMO panels. If you have a "Preferred Provider Option" (PPO) for your health insurance coverage, I will provide you with all the necessary information you will need to file your claim. All fees are due up front; any reimbursement you receive from your insurance company is to be kept by you.
4. If you are7 not able to afford the standard rate of $40.00 per session, please discuss it with me. I have a percentage of slots reserved for lower-paying clients, and if one of those is open, I will make it available to you. We may also meet less frequently if needed. If your financial circumstances improve, please let me know so that I could make the reduced-fee slot available to someone else. I can also provide you with other counseling agencies that provide therapy on a sliding fee scale. I cannot ethically accept barter for therapy. If you accumulate a debt and eventually refuse to pay it, therapy will be terminated and I reserve the right to give your name and the amount due to a collection agency.

EMAIL & TEXT MESSAGE COMMUNICATION:

<u>Please initial below, beneath the signature lines, if you wish to communicate via email, or text message.</u> By initialing, you acknowledge that you understand the vulnerability inherent in these communications but accept that they are a way of life and are convenient ways to communicate non-clinical information. It is my responsibility to inform you that your confidentiality cannot be guaranteed when we communicate this way.

CLIENT CONSENT TO PSYCHOTHERAPY SERVICES:

I HAVE READ THIS STATEMENT, HAD SUFFICIENT TIME TO BE SURE THAT I CONSIDERED IT CAREFULLY, AND I UNDERSTAND THE INFORMATION OUTLINED ABOVE. I UNDERSTAND MY RIGHTS AND RESPONSIBILITIES AS A CLIENT, AND MY THERAPIST'S RESPONSIBILITIES TO ME. WITH THIS UNDERSTANDING, I AGREE TO UNDERTAKE THERAPY WITH JAIMIE BAECKER, LMHC.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

CONSENT FOR TREATMENT OF MINORS (if applicable):

I/We, _____, the guardian (s) of _____, give Jaimie D Baecker, LMHC permission to provide psychotherapy services to my child. I recognize that I have a duty to be reasonably available to provide consent to changes in my child's treatment and to participate in treatment as deemed necessary and appropriate.

******In the event of separation or divorce, it is understood that **BOTH** parents, regardless of custody, must sign this form **BEFORE** services can be rendered to a minor. (A notarized original may be sent by mail). As well, documentation of the custody arrangement must be provided and a copy will be kept in the file.

Parent Signature (or legal custodian):_____ Date: _____

Parent Signature (or legal custodian):_____ Date: _____

FEE ACKNOWLEDGMENT AND AGREEMENT

I have been informed of the session fees and agree to pay _____ per session. I agree to inform the therapist if this becomes a hardship and to discuss alternative options.

_____ Date: _____

ACKNOWLEDGMENT OF INFORMATION **Please initial:**

_____ I/We acknowledge that I have received a copy of this form.

_____ I/We acknowledge that I have refused a copy of this form

CONSENT TO RECEIVE EMAIL OR TEXT COMMUNICATION **Please Initial:**

_____ I consent to electronic communication regarding scheduling or non-clinical questions.

_____ I DO NOT consent to electronic communication