Schafer Consulting LLC

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DISCLOSURE STATEMENT *and* CONSENT TO TREATMENT

My Training and Credentials:

Thank you for choosing to work with me to meet your emotional and mental health needs. For my credentials, I received a bachelor's degree in behavioral science at Grand Valley State University and a master of arts in counseling psychology at Moody Theological Seminary. I have a limited license in psychology through the state of Michigan, allowing me to provide mental health services and requiring me to invest in continuing education and meeting with a supervisor for two hours a month.

I work with individuals, parent-child / teen dynamics and couples as an independent contract helping clients with multiple issues including: depression, anxiety, OCD, ADHD, behavioral problems and relationship issues. While I do not provide emergency services or prescribe medication, I invite doctors, hospitals as well as school counselors and teachers to collaborate care with me.

Therapy Details:

Therapy sessions last between 45 and 60 minutes, usually held once a week, especially at the beginning of treatment and then decreasing depending on each individualized treatment plan. The initial session is used for assessment, gathering important biopsychosocial information and learning about the problem clients would like addressed in therapy. Additional sessions will be used in forming a treatment plan, carrying out the treatment plan and reviews of the plan.

Obligation for payment is not dependent on the client receiving reimbursement from their insurance company. While I work diligently with my biller to help support clients in receiving the highest amount of reimbursement from their insurance companies, it is ultimately the client's responsibility to insure they receive their full amount of reimbursement. **All copays and deductibles are due at the time of service. For clients not using their insurance for services, my Out-of-Pocket fee for services is $100 per session.** Session fees cover therapy services for individuals and families, ongoing assessments, treatment planning and time collaborating with other professionals. Report writing, letters and other forms to be fill out is charged at $100 per hour. It is my practice to keep a credit card/debit card on file for all clients in order to charge for any remaining balance at the end of therapy, for copays or missed session fees. Please also note that your balance may be sent to a collections agency at my discretion.

Client Rights and Responsibilities:

While I respect your choice to end therapy at any time, you will be responsible for attending any scheduled sessions. **Unless a session is cancelled 24 hours in advance, you are responsible for a no-show / late cancellation fee for the missed session. Fees for missed sessions are $75.** If too high of a balance accrues for a client's account, either scheduling of sessions will be paused until a payment can be made or the client may be discharged and referred to another mental health organization.

Information discussed in session or written on forms is kept confidential, not being revealed to any other person or agency without clients' written permission. However, there are a few circumstances that require me as a mental health professional and mandated reporter to share information obtained in session without your permission. These exceptions include: if you threaten serious bodily harm to yourself or to another person, if I am subpoenaed by a court of law to provide specific information or if there is information revealed about an abused or neglected child or vulnerable adult.

After you have read this information and have received satisfactory answers to any questions which may have surfaced, please sign this contract below. Anyone over the age of 18 must sign this form in order to be treated. Parents or legal guardians must sign for persons under the age of 18.

I have read and understand the information provided in this document and agree to the procedures and conditions outlined. I understand that I may terminate therapy at any time, but will be financially responsible for those sessions already completed.

PRINTED NAME OF PATIENT

PATIENT'S SIGNATURE (GUARDIAN'S SIGNATURE FOR A MINOR) DATE

THERAPIST'S SIGNATURE DATE

Insurance Consent:

By signing below, I give Schafer Consulting, LLC permission to release all required information to my insurance company to attain payment for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

SIGNATURE OF INSURED DATE

Supervision Requirements:

As previously stated, with my limited license in psychology, I am required to meet with my fully license supervision for two hours a month. My supervisor and I regularly review various client's cases to make sure I am providing the best services for my clients.

By signing below, you are giving permission to have your personal health information shared in a case consultation with other professions to ensure the best quality of care.

PATIENT'S SIGNATURE (GUARDIAN'S SIGNATURE FOR A MINOR) DATE

HIPAA Privacy Disclosure:

Please be advised that communication via cell phone and **unencrypted emails** are not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls, texts and **unencrypted emails** cannot be guaranteed.

PATIENT'S SIGNATURE (GUARDIAN'S SIGNATURE FOR A MINOR) DATE