WELLSPRING COUNSELING

1335 Dublin Rs. Suite 208D
Columbus, OH 43215
614-538-0353

Clinician:

DISCLOSURE AND CONSENT

I am pleased that you have selected me to be your counselor. This document is designed to inform you about my background to ensure that you understand our professional relationship.

I. I have been approved by the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board as a _____. I have completed/am working on a Masters of Arts in Clinical Mental Health counseling from _____.

II. I am under supervision with _____ and will consult with her/him and other clinical clinicians during our regular supervision times.

II. **Philosophy** Counseling/Outpatient Therapy is a collaboration between you and I for the purpose of addressing personal, relational, and mental health problems. I will provide you with a forum for confidential disclosure, support, diagnosis, a plan for treatment developed with you, and counseling which will include encouragement, teaching of therapeutic skills, suggestions on strategies for managing symptoms and working toward resolution of relational difficulties, suggestions fore reading/education, and referrals to other helping professionals if needed. I believe that doing homework outside the counseling session can benefit progress and growth. I have a Christian world view and offer a faith based positive approach which will include prayer and biblical emphasis if requested by you. I accept patients into my practice who I believe have the capacity to better manage and resolve their issues with amy assistance. Some clients only need a few sessions to make the changes they desire and others may require longer term therapy. the first few sessions are diagnostic in nature to determine whether further treatment with me is appropriate and to establish goals for treatment. My services will be provided in a professional and ethical manner consistent with accepted ethical standards.

III. **Professional Relationship**: Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. Thank you for not inviting me to social gatherings, offer gifts, or ask me to relate to you in any way other than in the professional context of our counseling sessions. You will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your concerns. I do not counsel over email, Skype, or through texting. Please schedule an appointment.

IV. **Confidentiality**: I will keep confidential anything you say, with the following exceptions: 1) You direct me in writing to exchange information with someone else, 2) I determine that you are in danger to yourself or others, 3)I suspect child or elder abuse or neglect, 4) on the rare occasion that a court subpoenas records. 5) when information needs to be shared with our Administrative Assistance, you insurance company or a collection agency for the purposes of billing. By signing this document you as a client acknowledge that you understand and are aware of the level of risk inherent to client confidentiality when using or requesting any form of electronic data transmissions (email, fax, voicemail), as these forms of communication cannot be guaranteed to be secure and may be intercepted by a third party. Please also be advised that either parent could potentially request the records of minor children. NOte that confidentiality is considered to be waived if myself and/or WellSpring Counseling, LLC, are named as defendants in a lawsuit brought on your behalf.

V. **Court Testimony**: I will only provide testimony on treatment facts, and will make no recommendations, if subpoenaed to testify regarding an adult or a minor.

VI. **Emergency**: If an emergency occurs and I am unable to keep our appointment or contact you to inform you, WellSpring has access to your name, phone number and email address to let you know my situation. If you are experiencing a mental health emergency, please contact Netcare at 614-276-2273 , call 911 or go to your nearest hospital emergency room.

VIII. **Concerns**: If at any time you are dissatisfied with my services, please let me know. If I am unable to resolve your concerns, you may report your complaint to my supervisor, _____ or to the Clinical Director of WellSpring _____ and/or to the Counselor, Social Worker, Marriage and Family Therapist Board.

Furthermore, I would appreciate your feedback at the end of counseling. Please go to the following link https://goo.gl/JankLw or visit our website, WellSpringColumbus.org and go to the Resources page and fill out the Feedback Survey.

IX. **Insurance Benefits**: The client/guarantor is responsible to verify and know their insurance benefits regarding treatment and paying for counseling. WellSpring will bill your insurance company based on the information you provide, however, you are responsible for fees incurred, including copays, deductibles, and missed or late cancellations.Billable rate for using insurance is $110 to $125 for a counseling hour (50 minutes)

Direct pay rates: Independently Licensed: $100 (for 50 mins)
Licensed: $70 (for 50 mins)
Intern: $40 (for 50 mins)
Late Cancellations:(Less than 24 hours) 50% of session fee
Missed Appointment: 100% of session fee
Returned check: $25.00

Intake sessions may be longer in length and vary in price depending on the clinician.

I will store your credit card information on our electronic system and run your card for the above with your approval. If however, I try to contact you three times for approval and cannot get your approval, I reserve the right to charge your card for the amount owed.

XI. **Agreement**: Finally by signing this document the client agrees to the following, "I the client agree that if I subpoena, depose, or request documentation from anyone at Wellspring Counseling I will pay Wellspring Counseling for time spent at the clinician's full rate of pay per hour, as well as, cover the clinician's legal fees for any legal counsel retained for the purpose of meeting the needs of the client's requested service.

_____ _____

Client's signature/date Counselor's signature/date

This information is required by the board which regulates all licensed counselors:
Counselor, Social Worker, Marriage and Family Therapist Board
77 S. High St. 24th Floor, Columbus, OH 43215 614-466-0912