INFORMED CONSENT

Thank you for choosing B. Empowered Counseling LLC. Today's appointment will take approximately 45 – 50 minutes. 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. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Dr. Catherine Oliver has earned a Bachelor's Degree in Psychology, a Masters Degree in Social Work, and a Doctoral Degree in Social Work from Aurora University. She is licensed by the State of Illinois as a Licensed Clinical Social Worker. She has over 10+ years of clinical experience in treating adolescents, adults and families using individual and family therapy and specializing in treating children. Dr. Oliver practices standard psychoanalytic, narrative, and cognitive behavioral therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you are determined to be a clear and present danger to yourself or others, developmentally or intellectually disabled then I am mandated to report you to the Department of Human Services d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law.*

In the unlikely event that I am unable to provide ongoing services the owners or co-owners of B. Empowered Counseling LLC will provide or dictate those services and will maintain your records for a period of 7 years. The owners of B. Empowered Counseling LLC; Kathleen Baxa, LCPC or Dr. Catherine Oliver, LCSW, may be contacted through current contact information provided at www.bempoweredcounseling.com. If an emergency situation for which the client or their guardian feels immediate attention is necessary the client or guardian understands that they are to contact the emergency services in the community (911) for those services. B. Empowered Counseling LLC will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential, and I may not be able to respond. If you choose to make use of e-mail, text messaging, or social media to reach me, you are accepting sole responsibility for the transfer of information and releasing me of any associated risk with these forms of communication.

***Signature(s)*_____*Date:*_____**

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, responsible party or third-party payer for you if you wish. We ask that at each session you pay your co-pay or 100% of the fee if your deductible has not yet been met for the year. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to B. Empowered Counseling LLC.*
I have received a copy of my fee schedule _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed 60.00 per missed session. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. ***You may have a copy of this form if requested.***

***Signature(s)*_____*Date*_____**

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*
May we contact you at home (circle one)? ***yes no***
May we contact you at work? ***yes no***
May we contact you by cell phone? ***yes no***

Where may we contact you? _____

Signature(s)_____Date_____

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. If you prefer to decline consent no information will be shared.*
____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that _____ may be treated as a client by B. Empowered Counseling LLC. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.*

Signature(s)_____***Date***_____

CREDIT CARD ON FILE:

You may place a credit card or medical benefits card on file for the purpose of balancing your account. By doing so, you authorize B. Empowered Counseling LLC to charge your assigned card for any account balance or fees owed to B. Empowered Counseling LLC after insurance has been processed. If you would like to do this, please fill in the below information:

Name on Credit Card:
Credit Card Number:
Expiry Date:
CVV:
Zip Code of Billing Address:

Signature(s)_____Date_____