

2020 Raybrook Ave SE, Suite 305
Grand Rapids, MI 49546
Phone (616) 202-4444 Fax (844) 848-9346

 advancedcounselingandtherapyservices.com

|  |
| --- |
| **Welcome** |

|  |
| --- |
| Our goal is to provide thoughtful and effective counseling services to you in a respectful and caring atmosphere. Please take the time to review the following information and feel free to ask any questions you may have. |

|  |
| --- |
| **The Counseling Process and Informed Consent** |

|  |
| --- |
| As part of the counseling process, we will begin with several sessions to explore the nature of your concerns, some family history as well as your strengths and support system. We will talk about what you care about and what you want for yourself. If you are seeking services for your child, the assessment will include conversations with you as the parent as well as play-based therapeutic activities designed to put your child at ease and engage him/her in the counseling process. You will be given some feedback and together we will develop an individualized treatment plan and meet regularly for sessions by appointment to work towards your goals. You should expect to be an active participant in the process, along with other family members as needed. At times we may help you to identify choices and alternatives and you will decide if you want to try them. As sometimes it is difficult to talk about problems, counseling may lead some people to experience unwanted feelings such as sadness, guilt, anger or anxiety. Please share your reactions as openly as possible. |

|  |
| --- |
| **Confidentiality** |

|  |
| --- |
| Your participation in counseling is strictly protected by federal law, and we take that responsibility seriously. Disclosures to other providers or persons can only be made with your permission, as except as required by law or subpoena. As mandated reporters, we must report suspicions of child abuse and maltreatment to the authorities, and must take action to keep you and others safe in the face of threats of harm to self or others. Your insurer will be given information about your treatment only as it pertains to establishing the necessity of care. |

|  |
| --- |
| **Counselor’s Responsibilities** |

|  |
| --- |
| We are responsible for providing high quality care and responding to your problems and concerns with recommendations based on best practice and ongoing consultation and supervision. Only non-identifying information is shared in these consultation sessions. At times these recommendations may include consulting with another provider, such as a psychiatrist, or participation in another therapeutic activity designed to promote growth, such as a support group or specialized treatment program. For any concerns you have regarding your protected health information, you may visit https://www.HHS.gov/hipaa. |

|  |
| --- |
| **Termination and Evaluation** |

|  |
| --- |
| Although you may end treatment at any time, we firmly recommend that you share your desire to end treatment and process this decision in at least one final face to face meeting, rather than terminating by phone or mail. |

|  |
| --- |
| **Appointments** |

|  |
| --- |
| Our office works on an appointment basis. Your appointment will typically last 45-50 minutes. This time has been set aside for you and it is important that you arrive promptly and keep your scheduled appointments. If you need to cancel, please do so at least 24 hours ahead. *Missed appointments and late cancellations will be charged a fee, which is not covered by your insurance.*If your insurance covers services, we will bill them accordingly. You are responsible for your copay **at the time of service**. It is important to stay current with payments and copays to prevent interruptions in treatment. Please notify your therapist promptly of any changes in coverage. Thank you for taking the time to review these policies, and we look forward to working with you. |

|  |
| --- |
| I have read the Welcome Letter and understand my rights regarding HIPAA and confidentiality. I also understand my responsibility regarding late cancellations and no-show charges. I have had the opportunity to ask questions of my therapist regarding the above mentioned information.   |

|  |
| --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Responsible Party Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Therapist Date |
|  |