

Client Consent for Treatment and Limits of Liability

Limits of Services and Assumption of Risks:

I understand that therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

I understand that the therapist **will not** provide any of the following services:

- Custody or Court Evaluations
- Personality, Ability, Achievement, or Aptitude of Vocational Interest or Evaluations
- Prescription of Medication
- Treatment of Severe Mental Illness or Substance Abuse

Relational/Family Treatment:

I understand that when more than one family member is being seen in therapy, the therapist views the couple or family unit as the client. Therefore, releases of information regarding the family require approval of each consenting member of the family who was present at any time during treatment. There may be instances when the therapist(s) will split up certain parts of the family or couple. When/if this occurs, the therapist will use his best judgment as to whether, when, and to what extent he will make disclosures to the treatment unit regarding the separate session(s). The therapist also retains the right to enact a **no secrets policy** when/if he considers client disclosures detrimental or inhibiting to further couple or family treatment, at which point, the therapist may halt treatment altogether or adjust treatment to give the individual or smaller part of treatment unit the opportunity to make the disclosures to the entire treatment unit.

Client Rights/ Limits of Confidentiality:

I understand that I can inquire about: the nature, length and cost of treatment, the limits of confidentiality (as explained below), consequences of my/our treatment, and emergency procedures at any time and review my treatment plan with my therapist. I also understand that I am free to discontinue treatment at any time and request a referral from my therapist.

I understand that all personal information and information disclosed within these sessions is confidential and will not be revealed to anyone outside the therapy team without written permission, except as required by law. **The law may require disclosure of information in the following circumstances:**

1. If there is a reasonable suspicion of child abuse/neglect or abuse/neglect to a dependent or elder adult.
2. If a client communicates a threat of bodily injury or worse to self or others, the proper authorities must be notified and any potential victim(s) as well.
3. If a client is suicidal.
4. If disclosure is required pursuant to legal proceeding.

5. If the client is in a probation or parole period or other legal situation that would require disclosure.
6. When parents or legal guardians of non-emancipated minor clients have the legal right to access the clients' records.

I understand that, if one of these circumstances applies, the therapist has a duty to report confidential information to the Police, the Department of Human Resources, or a minor's legal guardian(s).

Cancellation Policy:

I understand that, if I am unable to attend an appointment, I must provide no less than a 24 hours advanced notice. If I do not, I understand that I will be billed for the entire cost of the scheduled appointment, since the therapist will no longer be able to utilize that scheduled time. This policy does not apply for late cancellations due to emergencies or illnesses.

I understand that, if I fail to provide a timely cancellation one of the following will occur: 1) my credit card on file will be charged for the entire cost of the scheduled appointment; 2) a bill will be direct mailed to me for the entire cost of the scheduled appointment.

We appreciate your help in keeping our shared schedules running timely and effectively.

Financial Agreement:

I understand that Michael King charges \$40 per individual session and \$50 per couple or family session. If a family is deemed the unit of treatment, then the \$50 charge applies even if only part of the unit is present in session.

I consent to allow Down To Earth Counseling to charge my credit card (provided below) for therapy services for the duration of treatment, including any late cancellation fees I may accrue. I understand that Down To Earth Counseling uses a HIPAA compliant payment medium for credit cards.

I understand that, if at any point, the therapist is required to enter into legal proceedings of any type on behalf of, or at the behest of, clients or any legal entity, his charges will adjust to \$150 per hour of services provided, regardless of the service or the client type.

I understand that the therapist retains the right to discontinue therapeutic services due to nonpayment.

Contact With/From Therapist:

I agree to allow Michael King to contact me at the source(s) listed below and to communicate via the means listed below. Furthermore, I understand that certain sources and means of communication are not completely secure and that I, and not the therapist, am responsible for keeping text messages, emails, or voicemails secure and confidential on my device(s). I understand that I am not required to authorize the use of any particular means of communication.

I consent to my therapist leaving me voicemails on the phone number I provided _____(initials)

I consent to my therapist leaving text messages on the phone number I provided _____(initials)

I consent to my therapist emailing me on the email address I provided _____(initials)

I understand that communication via any means other than face-to-face is limited to scheduling purposes alone and that the therapist will not provide treatment outside of face-to-face communication, with the exception of providing resources in the event of a crisis circumstance.

Therapist Information:

I understand that Michael King is a graduate student in the Marriage and Family Therapy Program at The University of Alabama and that he is currently practicing under the professional licensure and supervision of Dr. Karly Downs, Assistant Professor and Clinical Director of the Capstone Family Therapy Clinic. Said therapist may also receive professional consultations from Greg Evans of Down to Earth Counseling. **I understand that supervision/consultation necessitates my information being shared confidentially, and for professional, therapeutic purposes only, with Dr. Karly Downs and/or Greg Evans – both licensed, professional psychotherapists.**

At any time, you may reach Dr. Karly Downs with questions or concerns at 205-348-6660 or by email at kdowns@ches.ua.edu. You may contact Greg Evans at 205-394-3555 or by email at greg@downtoearthcounseling.com.

I have read the above information, consent to treatment, and agree to the terms of treatment.

(Please ask any questions for clarification before signing).

Client Signature/Name (if a Minor) _____
Date

Client Signature/Signature of Minor's Legal Guardian _____ Date

Client Signature _____
Date

Client Signature _____
Date

Client Signature _____
Date

