GENESIS COUNSELING

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/
Informed Consent for Services/Professional Disclosure Statement

The undersigned Client or Responsible Party (parent, legal guardian, or conservator) consents to and authorizes services by Genesis Counseling, LLC. These services may include psychotherapy, cognitive behavioral therapy, telehealth services, education, and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

- Be informed and participate in the selection of treatment services
- Receive a copy of this consent form
- Withdraw this consent at any time

Financial Responsibility: I am aware that I am fully responsible for the session fee at the time of service. I understand that if I do not appear for a scheduled appointment or less than 24 hours' notice is given for cancellation of an appointment, I will be responsible for the full fee of the session.

Minors & Parents: For minor children, parents may be asked to give up access to their child's records, other than general information about the progress of the child's treatment and their attendance at scheduled sessions, unless the counselor feels the child is in danger to themselves or others or the child provides written authorization. Before giving parents any information, the counselor will discuss the matter with the child, if possible, and address any objections they may have.

Custody Issues: Our office does not conduct assessments or yield recommendations regarding custody. Our services are to respond to a child's emotional and behavioral needs rather than evaluate custody issues. Therefore, if a custody evaluation is needed, you will be directed to sources outside of this office.

Legal Issues: Because our counselors are not forensic specialists, be advised that we do not provide to attorneys, oral or written reports, assessments or evaluations regarding our clients without the client's written consent or pursuant to a court order. Our counselors do not appear in court on behalf of clients to provide oral or written reports of any kind regarding their counseling treatment unless validly subpoenaed.

In the event that a counselor is subpoenaed to appear in court regarding their client's case, the client will be responsible for all document costs, preparation time, travel time, and time in court, as well as any legal fees incurred by Genesis Counseling, LLC on the client's behalf. Charges will be calculated at the rate of $250.00 per hour for preparation time, travel time, and time in court.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge more per hour for preparation and attendance at any legal proceeding.

Video-Conferencing: Although HIPAA compliant platforms are used, confidentiality cannot be guaranteed when participating in telehealth services using video-conferencing over the internet.

Email Communication: Email is NOT a confidential communication medium. Confidentiality cannot be guaranteed when transmitting information and/or requesting a written response to a question posed in an email.

Referral to other professionals: If, during the course of our work together, we discover problems outside of the range of my expertise, I will help and encourage you to obtain the required services from an

appropriate professional.
I will notify Genesis Counseling, LLC of any changes to my contact information or medical history. In the event of an emergency, I understand that I am to report to the nearest emergency room for services. This file will be closed if there is no activity for 90 days.

BY COMPLETING THE FORM BELOW, I INDICATE THAT I HAVE RECEIVED THE INFORMED CONSENT FOR SERVICES/PROFESSIONAL DISCLOSURE STATEMENT. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF MY COUNSELOR IS AN INTERN UNDER SUPERVISION AT GENESIS COUNSELING, THEY WILL CONSULT WITH THE SUPERVISOR, DR. JON THOMPSON ABOUT MY CASE.

(Print Client's Name) **(Client's Date of Birth)**

(Client Signature, if 14 years old or older) **(Date)**

(If Client is a Minor, Print Parent/Guardian's Name) **(Relationship to Client)**

(Parent/Guardian's Signature) **(Date)**

Authorization to Release Information

Purpose: This section of the form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than you.

I, _____, authorize the following person(s) to have access to information covered
(Client's Name if 14yrs old or older/Parent's Name)

under the Privacy Practice regarding _____.
(Client's Name)

(Please Print Name) (Relationship)

(Please Print Name) (Relationship)

(Please Print Name) (Relationship)

(Client Signature, if 14 years old or older) **(Date)**

(If Client is a Minor, Print Parent/Guardian's Name) **(Relationship to Client)**

(Parent/Guardian's Signature) **(Date)**