CLIENT INFORMATION AND CONSENT FOR TREATMENT

Jessica Sagastume, LMHC, NCC

Licensed Mental Health Counselor #MH16756

Florida Family Certified Mediator

Training and professional background:

Jessica Sagastume earned her Master's degree in Clinical Mental Health Counseling at the University of Central Florida. She received her Bachelor of Science degree in Legal Studies at Florida Gulf Coast University. Jessica has had extensive training in the mental health field including two semesters at the University of Central Florida's Community Counseling Clinic, as well as, completed her internship at Florida Hospital's Center for Family Care. Jessica has worked with individuals and couples struggling with various issues including: medical issues, suicidal thoughts, anxiety, depression, grief, and relational problems. Jessica's theoretical counseling approach is primarily focused CBT and SFBT. Counseling may include other therapeutic modalities and interventions as deemed fit by therapist and client.

Client Information:

Counseling sessions are 50 minutes in length. Clients' length of treatment will be determined by therapist and clients through a mutually agreed upon therapeutic treatment plan. Cost of services will be discussed with by counselor with client prior to starting services. Payment will be collected at the beginning of session. Payment methods accepted are cash and debit/credit cards. You will be asked to fill out counseling assessments periodically, as deemed appropriate by the therapist to determine clients' progress. Note: I reserve the right to increase the rates, including reduced fee rates, at the start of each year by $5.

Client rights in counseling:

It is appropriate to raise questions to the counselor about therapeutic approach, the progress of therapy, and any other questions/concerns. It is also the client's right to choose the counselor and counseling modality which best suits their needs. Clients also have the right to request a change in counseling approach, and referral to another therapist or termination at any time. Additionally, the therapist is bound by the ethical codes of her professional organizations, by the laws of the State of Florida, as well as, by agency policy regarding special nature of the therapist-client relationship. It is expected that the therapist continually be aware of the influential position they hold in relationship with clients, using influence in a constructive manner. If a client thinks his/her counselor is not meeting ethical responsibility, he/she has the right to address concerns with the therapist and agency.

Appointment Times and Appointment Cancellations:

Fees are collected at time of service; no exceptions can be made. Missed appointments that are not cancelled will be charged 60% of the session fee. Cancelled appointments **require a 24-hour notice**. If a 24-hour notice is not given, it will result in a $30 charge for individual and $60 charge for couple/family sessions, in addition to the standard office fee and will be collected on the next scheduled appointment. A credit card is required to be placed in the system in a case that a "no show" or late notice fee needs to be charged. The card will not be used for any other purposes.

Confidentiality:

Therapist adheres to both the ethical standards of the American Counseling Association (ACA) and the Laws and Rules of the State of Florida. The information shared during the counseling process will be kept strictly confidential, except for those reasons required by law. These exceptions include the following:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. Information will only be shared with a person or organization that is able to help prevent or reduce the threat.
2. When there is suspected abuse or neglect of a child, elderly person, resident of an institution, or a disabled person.
3. As a result of any lawsuit against the counselor and/or legal/court proceedings.
4. If a law enforcement official requires a release.
5. When you (the client) explicitly request in writing that information be shared with a third party.

(ACA Code of Ethics [2005], Section B.2; Chapter 491, state of Florida law governing the practice of Clinical, Counseling, and Psychotherapy Services [2010], Section 491.0147)

For Minor Clients:
The therapist respects the rights of parents/legal guardians. Confidentiality cannot be given without the permission of parents/legal guardians. The reality is that a child/adolescent will have no reason to talk to a counselor if the counselor were to disclose all communications to a parent/legal guardian. Due to this problem, we ask you to permit your child to have a confidential relationship with the counselor assigned to them.

Disclaimer:
In signing below, I acknowledge that the therapist will not provide clients with diagnoses, clinical notes, court mandated paperwork, work, school or academic assessments or disability assessments. Additionally, therapist does not provide expert witness testimony and/or legal services. The therapist will **ONLY** provide clients with a treatment summary letter by request.

Consent for Treatment:
In signing below, I acknowledge that I have received, read and understand this **Client Information and Consent for Treatment form.** I have had an opportunity to ask questions and receive answers. I do hereby seek and consent to take part in treatment by the Therapist named below. I understand that treatment may include individual, couples, family or group counseling and can include consultations with other associates and medical providers of this agency. The treatment may also include referrals to other appropriate State, County, and/or professional agencies for further counseling. I understand that developing a treatment plan with the Counselor and regularly reviewing our work toward meeting the treatment goals are in my best interests. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by the Counselor. I am aware that I may stop my treatment with the Counselor at any time. I acknowledge that the therapist is a Florida Registered Intern Counselor, and give my permission to have my counselor's supervisors review all aspects of my treatment.

For Minor Clients:
By signing below, I certify that I give permission to the therapist listed below for treatment of my minor child. This document permits my child to have a confidential counseling relationship with the Counselor. I understand that the information disclosed by my child is private (outside the limits established above).

My signature on this document shows that I understand and agree with the above conditions and statements.

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Client(s) Printed Name

_____ _____

Client Signature **Date**

_____ _____

Client Signature **Date**

_____ _____

Therapist Signature **Date**

For Minor clients

_____

Parent(s)/Guardian(s) Printed Name

_____ _____

Parent(s)/Guardian(s) Signature (for minor clients) **Date**

_____ _____

Parent(s)/Guardian(s) Signature (for minor clients) **Date**