Kathy B Spurlock, LPC

523 Wait Ave. Wake Forest, NC 27587
Phone: (919) 272-8908

Informed Consent for Treatment

I, _____(client name) hereby consent to receive therapy from Kathy Spurlock LPC (practitioner) for a mental health and/or substance abuse condition. I understand that I will be given the opportunity to participate in the formation of my treatment plan, that the nature of the therapy will be explained to me, and that I can terminate my therapy at any time by notifying the therapist. I agree to discuss the termination with the therapist at a regular therapy session so that discharge plans can be made jointly.

CONFIDENTIALITY: I understand that my information is confidential and will not be shared with anyone outside the therapy practice without my written and informed consent, except under the following situations: I am in danger of hurting myself or someone else, child abuse is disclosed or suspected, my records are subpoenaed by the court, or I have given my written consent for release of my information. Additionally, even in the case where written consent has been given, the information will be shared judiciously, so as to protect my privacy. I understand that by signing this consent, I am agreeing to the disclosure of confidential information as is necessary to get certification, authorization or payment for my treatment, or as required by the terms of the contract with my insurance or managed care company. In order for my insurance company to cover my treatment, I understand that the therapist may have to share details of my condition and treatment with them. I also understand that I am giving consent for therapist to engage in any appeals that may be necessary to obtain payment for an insurance claim.
Parents and legal guardians generally have the right to make health care decisions for their children and so are by default considered the personal representatives for decisions, use and disclosure about protected health information for un-emancipated minors. In addition, in order for treatment with children to be effective, I understand that the therapist will require the young person to also consent to treatment. I also understand that by law, when a personal representative agrees to a confidential relationship between a health care provider and a minor, the personal representative does not have access to information associated with that relationship except as granted by the minor.
The purpose of this therapist providing therapy for children is not to make custody decisions, although referrals can be provided for that service. Therefore, I agree not to request or subpoena this therapist or her records, for custody issues or other court proceedings. The exception to this is when there is clear, observable abuse, in which case I understand that this will be discussed with the proper authorities as required by law.
I understand that in case of separated or divorced parents, both parents must agree to therapy and sign this form, unless one parent's rights have been terminated, or therapy has been court ordered.
I understand that the therapist may leave brief messages on my voice mail or email changing or canceling an appointment. I have the right to notify the therapist if I have a preference as to how this information will be communicated.

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I understand that in order for therapist to provide the highest quality of service possible, therapist may consult with other professionals regarding my situation; however, my full name will not be disclosed.
I understand that all records are kept for a period of six years after the last date of service, and after that all records are shredded.

INSURANCE: As a courtesy, most insurance plans are accepted and filed. This is provided through a billing service and information regarding biller is available upon request. I understand that by signing this form, I am granting permission for therapist to use said biller. I understand that I am responsible for the cost of services and that payment is expected each time I come for treatment. I may be responsible for more than my co-payment if insurance coverage is unavailable. In order to file insurance claims, accurate, complete and updated information regarding my insurance coverage is necessary. Therapist reserves the right to expect full payment for services at the time they are provided if necessary billing information is not provided. I am expected to notify therapist of any changes in insurance coverage. Additionally, many insurance companies require prior approval for mental health treatment. I understand that I am responsible for contacting the insurance company to obtain authorization for services. If required approval is not obtained, I understand that my insurance company may not cover the service, and I will ultimately be responsible for the charges.
I understand that by signing this form for a minor, I am responsible for any fees not covered by insurance, unless other arrangements have been agreed upon. Additionally, I understand that if another party does not consent to payment, I will be billed.

ADDITIONAL FEES: I will be charged a fee of **$75**, if I do not show for an appointment without canceling, and a **$50** fee if I cancel without 24 hours notice. I also understand that some services such as phone consultations and preparation of letters, reports, and/or forms, may not be covered by insurance, in which case I am responsible. Phone consult fees are based on length of time.

CRISIS: I understand that Kathy B. Spurlock, LPC is not an emergency service. In the event of a mental health emergency during evenings or weekends I will call Holly Hill Behavioral Health Systems, (919) 250-7000; Wake County Crisis Services, (919) 250-3133; Crisis Hopeline, (919) 231-4525, 911; or go to the nearest emergency room and ask for the Psychiatrist on call.

RISKS OF TREATMENT: I understand that entering into treatment does not guarantee success, that I am free to discontinue services at any time and that there are alternatives to outpatient psychotherapy to address my condition(s).It is distinctly understood that the practitioner is hereby fully released from any claims and demands, which might arise from treatment provided with ordinary care and professional responsibility. As with any treatment, mental health therapy comes with some risks. Change can be scary and uncomfortable, and can cause disruption to existing relationships. For example, family therapy may result in changes that benefit the family in general, but cause discomfort for an individual. This is usually temporary as new patterns and dynamics are developed. Additionally, treatment does not guarantee elimination of presenting symptoms or that symptoms will not worsen, including the continuation of behaviors that are illegal, unhealthy or may be harmful to self or others. There is

no predictable time table in which change occurs, and the process of change may be slow and frustrating. Many clients remain "stuck" due to external influences beyond the therapeutic relationship, or lack commitment to explore options and try alternatives. I understand that I am ultimately responsible for change or non-change.

SIGNATURES:

- I declare that I am legally competent and that I have the capacity to consent to my treatment or that of a family member for whom I am legal custodian or guardian.
- I understand and accept the terms as outlined in this statement regarding confidentiality, fees, client rights and responsibilities
- I understand that I am entering into a treatment contract with Kathy B. Spurlock, LPC and that even if insurance is being used, I am ultimately responsible and agree to pay all fees associated with services as outlined above.
- I understand what will occur in case of emergency.
- I understand that if insurance is being used, Kathy B. Spurlock, or an agent on her behalf, will be providing required information to the managed care/insurance company in order to receive payment for services
- I understand that consent for services can be withdrawn at any time and that treatment is always voluntary
- I understand that I may address any concerns with my therapist, my insurance company or the professional association regulating my therapist's practice.
- And finally, I understand the limitations of treatment, including that symptoms may get worse in the course of treatment and that no guarantees of treatment success are being made.

1._____ _____
Client Signature Date

2._____ _____
Client Signature Date

Consent for Treatment of a Minor:

I, the parent(s)/guardian(s) of _____ (client), give full and unconditional authority to proceed with clinical evaluation and treatment as recommended and provided by Kathy Spurlock, LPC (practitioner).

_____ _____
Signature(s) of Parent(s)/Guardian(s) *Date*

_____ _____
Witness *Date*