Willows Edge Counseling & Healing Arts Center
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INFORMED CONSENT / ORIENTATION

Welcome to Willows Edge, Inc. As a new client, the following outline of our program's policies will assist you in clarifying our expectations of your involvement in the treatment process to help ensure a successful, positive and rewarding experience. This will assist you in understanding what you can expect of various staff members while you are in treatment.

1. **Scheduled appointments**
   You should expect to keep all scheduled appointments. There is a required 24 hour minimum notice period of any intention to cancel a session. Failure to do so will result in a "no-show" fee being charged. Any exception to this policy will be determined by your primary therapist.

2. **Late Arrivals/ Grace Period**
   You will be seen for a session if you are no more than 15 minutes late for a scheduled session. If you are more than 15 minutes late, it will be up to your primary therapist to determine if you will be seen for this session or rescheduled. As we often have clients scheduled for sessions "back to back", if you arrive late for a session it may result in the next client having to wait. Think about your own feelings if you were to have to wait to see your therapist who is using your time to see a client who has arrived late. As we make every effort to be considerate of your time schedule, please provide the same consideration of others. We are not obligated to see you for a session if you are more than 15 minutes late.

3. **Appointment Dates/ Times**
   If for any unforeseen reason you leave without being given your next scheduled session, remember it is also your responsibility to make sure you are scheduled. Although we try our best to make sure our clients are given the best possible attention in scheduling, all situations cannot be foreseen. Please call your primary therapist or our general office number if you are unsure of your next session or time at 248-834-0614.

4. **Payment of Service**
   Payment for counseling is expected at the time of your session (unless you have insurance that fully covers each session) and must be made by cash, check, credit or money order. Any checks returned to the office are subject to an additional fee of up to $25.00 to cover any bank fees. If you refuse to pay any debts, we reserve the right to use an attorney or collection agency to secure payment. In addition to weekly appointments, other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service may be subject to additional fees and will be discussed as needed.

Clients arriving at Willows Edge without their fee will not be seen for their session and will be charged a "no show" fee. Any alternative arrangements are at the discretion of your therapist. We will make every effort to schedule sessions according to your schedule to allow you the opportunity to have your fee available.

5. **Partial Payment Fee**
   None, unless agreed upon by your individual therapist.

6. **Insurance**
   If you have a health insurance policy, it is your responsibility to contact your insurance prior to entering counseling to verify your coverage, understand if you need any prior authorizations, and know your deductible and any copays you may be responsible for. Our medical billing service will take care of submitting all in-network insurance claims. With your permission, our billing service and your therapist can assist you in filing claims for any out-of-network insurance claims.

   It is also important to be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. In some cases insurance companies my share this information with a nation medical informational databank. By signing this agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance. It is important to remember that you always have a right to pay for services yourself to avoid using insurance.

7. **Professional Records**
   Your records will be maintained in a secure location in the office. You have rights to parts of your file when requested in writing. You also have the right to request a copy of your file be made available to any other health care provider at your written request.

8. **Case Closures**
   I understand that I may be terminated from treatment non-voluntarily for the following reasons:
   1. If I exhibit physical violence, verbal abuse, carry weapons or engage in an illegal act within the clinic.
   2. If I refuse to comply with stipulated program case protocol or refuse to comply with treatment recommendations.

   I understand that I would be notified of non-voluntary discharge by my therapist, but this is seen as a last resort when other, less dramatic measures have been proven ineffective. I may appeal this decision with the director of the clinic or request to re-apply for services at a later date.

9. **Prescribed Medication**
   Please see your primary therapist regarding any medications you are taking or may have been prescribed for you while you are at Willows Edge.

10. **Bill of Rights and Notice of Confidentiality**
    As we are required to observe all Federal and State laws regarding confidentiality, we are unable to speak with anyone regarding your case unless you have signed a release allowing us to do so, even if you have given your

verbal Okay. We **MUST** have a release signed before we can discuss your case. Other information about your privacy rights are fully described in a separate document entitled Notice of Privacy Practices.

11. **Parents & Minors**
While privacy in therapy is crucial to successful progress; parental involvement can also be essential. All communication will require the child's agreement, unless there is a safety concern, in which case every effort will be made to notify the client of any intention to disclose information ahead of time.

12. **Correspondence to This Office**
If for any reason you cannot make a scheduled appointment and need to re-schedule, it is necessary that we speak with you personally (unless the client is a minor). This also applies to verifying appointment times or length of appointment times. Please do not have anyone call on your behalf. We will not respond to or acknowledge these calls.

13. **Questions**
All questions regarding these policies should be directed to your primary therapist for clarification.

CONSENT TO PSYCHOTHERAPY

By signing this, I acknowledge that I have read this Agreement, the Notice of Privacy Practices and Recipient Rights, and agree to their terms.

Client or Parent/ Guardian Signature: ____

Printed Name of Client or Parent/ Guardian: ____

Printed Name of Client if different from above: ____

Date: _________________

Therapist Signature: _______________________________ Date: _________________