HUDSON COUNSELING SERVICES, LLC
Bridge to Balance
(715) 531-6760
Fax (715) 531-6761
Mailing Address: P.O. Box 644 • Hudson, WI 54016 • Office Location: 901 Dominion Drive • Hudson, WI

# INFORMED CONSENT

**Process of Therapy**

Intake Policy and Procedure: The goals of the initial intake session are to complete a thorough client history and to gain information regarding the presenting issues. This is also a time to discuss the process of therapy and to answer any questions you may have. It is important to obtain informed consent before beginning the therapy process.

Scheduling: If you choose to go forward in therapy, sessions will be set up which are generally 45-60 minutes in length. Approval for 60 minute sessions will need to be obtained by some insurance companies through prior authorization; additional fees may apply for 60 minute sessions. Frequency of sessions will be determined based on need.

Therapy Goals:It is our procedure to work with you to identify therapeutic goals and to develop a treatment plan in the first two or three sessions. This plan provides a guide for therapy sessions and a basis for progress evaluation. Therapists do not do Forensic Consultations.

Therapy Process: Therapy is an investment of your time and energy. It will be of most benefit if you are active in identifying issues and working together towards change. You will make your own decisions. The therapist's role is to act as a guide, teacher, co-learner and companion in the therapy process. A closure session is often helpful at the end of therapy to summarize the course and progress in your work and to give you recommendations for the future.

Therapy is a commitment, it is often hard work, and it may not make you feel better. It is not for everyone and is only one option for addressing issues causing concern.

**Your Rights as a Client**

You are entitled to information about any procedures, methods of therapy, techniques, and possible duration of therapy.

You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. If you wish to see another therapist, the names of other qualified professionals whose services you might prefer can be provided.

You have the right to expect confidentiality. However, there are limitations to this right. I am required by mandatory reporting law to report: (a) if you threaten bodily harm to another person or yourself; (b) if you reveal information regarding the abuse or neglect of a child or vulnerable adult; (c) if a judge issues a signed court order; and (d) if you are in therapy by order of a court of law. Also, insurance companies require certain information in order to cover services. Parents have access to their children's records with certain exceptions.

At your written request, records can be released to any person or agency you designate once you have completed an authorization for release form. Also, you may authorize me to consult with another professional about your therapy.

You have the right to file a complaint with the state of Wisconsin Dept of Safety and Professional Services:

dsps.wi.gov
608-266-2112
877-617-1565

**Client Responsibilities:**

1. Taking an active part in counseling by sharing ideas and asking questions.
2. Being open to looking at problems in new ways and trying new behaviors.
3. Respecting the privacy of other people served by the agency.
4. Making a complaint if you are not satisfied with services you have received.

HUDSON COUNSELING SERVICES, LLC
Bridge to Balance
(715) 531-6760
Fax (715) 531-6761
Mailing Address: P.O. Box 644 • Hudson, WI 54016 • Office Location: 901 Dominion Drive • Hudson, WI

5. With respect to the right of the clinic, therapist may discontinue or refuse services due to the client's refusal to follow the treatment plan.
6. Any physical, emotional, or sexual harassment from the client to the therapist or staff may result in termination and an immediate appropriate referral.

**Financial Policy**

1. I understand that if my insurance company does not pay for treatment, I will be responsible for payment in full.
2. A **24-hour** business day notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay a late cancel fee of $55.00. I understand that this will be my responsibility, not that of the third-party payer. If you have 2 late cancels or failed appointments, all future appointments will be taken off the schedule.
3. I understand that it is my responsibility to be aware of my Behavioral Health Insurance Coverage.
4. Regarding Accounts Receivable: If at any time my balanced owed is at or above $250.00, I may be asked to reschedule to a time when my account is no longer at the limit or past due.
5. I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.
6. I understand I will be charged for returned checks as determined by state law.

**Consent to Treatment**

**I affirm that prior to becoming a client of Hudson Counseling Services, LLC, I was given sufficient information to understand the nature of therapy. I consent to participate in evaluation and treatment and I understand that I may refuse services at any time. I am aware that the therapist will participate in case consultation, as required, at the clinic. My signature below affirms my informed and voluntary consent to receive therapy.**

**I authorize HCS, LLC to send monthly statements to the party listed above and I consent for HCS, LLC to communicate any necessary financial information (which could include co-pays/deductibles, DOB, etc).**

I authorize appointment reminders to be via text:

Client Signature (18 yrs or older): _____ Date: _____

Parent/Guardian Signature (17 yrs or younger): _____ Date: _____

Therapist: _____ Date: _____