SHEEP GATE
CHRISTIAN COUNSELING

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INFORMED CONSENT

Welcome to Sheep Gate Christian Counseling, your pathway to healing and wholeness. Thank you for the privilege of serving you. Our goal is to provide you with outstanding customer service, sound biblical insight, quality psychotherapy, and effective outcome. We realize that starting counseling is a major decision, and you may have many questions. This document is intended to inform you of our policies and procedures, state and federal laws, and your rights. Carefully read the following information and prepare any questions or concerns you might have to discuss with your therapist during the initial assessment. Please sign the form below indicating that you understand and agree to the SGCC policies and procedures stated therein.

COUNSELOR DISCLOSURE AND LENGTH OF SESSION:
The psychotherapy session is approximately 45-50 minutes long (25-30 minutes for young children; 70-75 minute sessions may be prearranged with your therapist for an additional fee). Since your therapist has sessions scheduled after yours, the sessions must end at the scheduled time. Shyrielane Watson, MA, CAS, LCPC, NCC, has earned a Bachelor of Arts Degree in Psychology from the College of New Rochelle, a Master of Arts Degree in Counseling from Regent University, and a Certificate in Advance Studies in Pastoral Counseling from Loyola College in Maryland. She is also licensed by the State of MD as a Licensed Clinical Professional Counselor and is certified by the National Board for Certified Counselors (NBCC) as a National Certified Counselor. She has over 15 years of clinical experience in treating adults, children, and families using individual, group, and family therapy. Shyrielane practices standard cognitive-behavior therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan limitations, and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for a) information shared with business associates and/or consultants, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Maryland State Law, I am obligated to report this to the Department of Child/Adult Protective Services, d) where you sign a release of information to have specific information shared, e) if you provide information that informs me that you are in danger of harming yourself or others, f) information necessary for case supervision or consultation, and g) or when required by law. In the unlikely event that I cannot provide ongoing services, you will be notified by an SGCC representative who will coordinate your referral to another outpatient provider in the community. Sheep Gate Christian Counseling will maintain your records for a period of 7 years. Occasionally, the need to talk to your therapist may arise between normally scheduled sessions. It is difficult to conduct psychotherapy over the phone, but your therapist will respond to your call during normal business hours. A charge will be incurred by the patient for any telephone consultation time between scheduled sessions with his or her therapist. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Sheep Gate Christian Counseling will follow up on those emergency services with standard counseling and support to the client or the client's family.

Signature(s): _____ **Date:** _____

FINANCIAL/INSURANCE ISSUES: As a courtesy, we will bill your insurance company, HMO, the responsible party, or third-party payer for you if you wish. We expect that at each session, you will pay in full all co-pay, deductible, co-insurance, and cancellation fees. If your insurance company denies payment or does not cover counseling, it will be your responsibility to pay the balance not paid by your insurance at that time. **Please note that failure to notify us of any changes or termination in your insurance could result in your claim being denied by the insurance company.** If two therapy sessions are conducted without payment, future therapy sessions will be postponed until payment is made in full. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Sheep Gate Christian Counseling reserves the right to release your name, address, and telephone number to our collection agency. We ask that every client authorize payment of medical benefits directly to Sheep Gate Christian Counseling. We accept the following methods of payment: cash, check made payable to Sheep Gate Christian Counseling (SGCC), Visa, Master Card, and Discover. Telecheck provides our check service and will charge you a returned check fee of $35.00 without further notice, as permitted by law, if your check is returned unpaid for insufficient funds.

I have received a copy of my fee schedule _____ (initials)

CANCELLATIONS AND MISSED APPOINTMENTS: When an appointment is scheduled, that time is reserved for you. If the appointment is missed or canceled without sufficient notice, the therapist cannot make use of that time, and a cancellation fee of $50 will be billed. If you arrive late for your appointment, we cannot ethically bill your insurance the full fee for a 45-50 minute session, and we may have to reschedule or cancel your appointment. Therefore, if you need to cancel or reschedule an appointment, **please give 24 business hours advance notice; otherwise, you will be billed a $50 cancellation fee.** By 24 business hours, we mean that you must cancel between the hours of 9 am to 5 pm, Monday through Friday, to avoid being charged. **Please note that most insurance carriers do not cover missed appointments.** We sincerely appreciate your cooperation, and if at any time you have questions regarding insurance, fees, balances, or payments, please feel free to ask our staff. **You may have a copy of this form at your request.**

SCHEDULING: Normally, our counselors schedule clients into a particular time slot, which may initially be weekly or bi-weekly. Our policy is to allow one cancellation for every six months that you occupy a particular spot. The second time that you cancel an appointment, you risk either losing your spot or switching to another spot. If you opt not to pay the cancellation fee, we will consider your spot to be an open spot that could be filled by another client. If you choose to pay the cancellation fee, your spot will automatically be reserved for you.

Inclement Weather: Sheep Gate Christian Counseling will be opened as usual unless you receive a call from our office stating that we are closed. If you do not receive a call to this effect and you decide to cancel your appointment, you must still give 24 business hours advance notice in order to avoid the cancellation fee.

Please note: If you cancel with less than 24 hours' notice, the cancellation fee always applies.

Signature(s):_____ **Date:** _____

COORDINATION OF TREATMENT: It is important that all healthcare providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent, no information will be shared.

____You may inform my physician ____I decline to inform my physician

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

Signature(s): _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

I/We have received and read a copy of the Notice of Privacy Practices and Client Rights documents.

Signature(s): _____ **Date:**_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We_____ give Sheep Gate Christian Counseling and
(Parent/Guardian)
_____permission to provide treatment for_____
(Therapist) (Child)
_____permission to provide treatment for_____
(Therapist) (Child)
_____permission to provide treatment for_____
(Therapist) (Child)
_____permission to provide treatment for_____
(Therapist) (Child)

At times, it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.

Client Signature(s): _____ **Date:** _____

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

Therapist Signature: _____ **Date:**_____