

Client Information and Consent to Treatment/Disclosure Form

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Welcome. It is my desire to assist you in making informed decisions about your treatment. As a client of psychotherapy and as a consumer, you have certain rights. Therefore, I will explain the information you are entitled to know, such as my view of the therapeutic process, and my expectations for the cooperative working agreement. Please feel free to ask questions about any of the following information.

1. **Education and Training:** I obtained my Master of Arts degree in Contemplative Psychotherapy from Naropa University, in Boulder, Colorado. I am a Licensed Mental Health Counselor in the State of New York and Florida.
2. **The Therapeutic Process:** Counseling has both benefits and risks. Benefits for people who undertake counseling often include a reduction in feelings of distress, more satisfying relationships, increased clarity and resolution of specific problems. Growth nearly always brings change, and sometimes change (even positive change) causes stress. Potential risks of counseling involve recalling unpleasant aspects of your personal history that may bring up distressing thoughts and feelings. Every effort will be made to assist you to reach your therapeutic goals. If you have any concerns about your progress or the results of your counseling experience, please talk with me at any time during our work together.
3. **General Structure of Therapy Sessions:** I do psychotherapy in weekly or biweekly session of 50 minute periods. Length or frequency of sessions can be increased or decreased to reflect the therapy needs of the client. It should be noted that if a client arrives late for a session, he/she is still responsible for the total fee of the session.
4. **Canceling Information and Scheduling:** Clients must **call** to cancel a session equal to and/or no less than 48 hours in advance or he/she will be charged the full fee. Appointments can be made either by phone, face to face or by email. (Please note that I have a different fee cancellation policy for sliding fee scale clients).
5. **Payment:** My fee is \$110 (cash/check). Sessions can be increased or decreased as needed, wherein the cost would appropriately reflect this change. Payment is expected upon receipt of services. (In some cases involving Skype sessions, payment is expected before the start of the session.) Phone consultations of 15 minutes or more will be charged my office visit rates.
6. **Messages:** Every effort will be made to return calls and/or emails within a 24-hour period, unless otherwise stated. Please note that **all** messages left or sent after 5 pm on Thursdays may not be returned until the following Monday.
7. **Emergencies:** As my practice is not equipped to handle emergencies, please either dial 911 or head to your nearest emergency room. Please leave me a voice mail indicating you have done so.
8. **Confidentiality:** The information provided by and to a client during therapy sessions is legally confidential and will not be released without the client's signed consent. Exceptions to the rule of confidentiality apply in the following cases:
 - If I feel there is a threat of you harming yourself and/or other(s).
 - If I suspect child abuse/neglect or dependent adult abuse/neglect.
 - If legal matters are involved.
 - If there are collection proceedings.

- If there is a court order for counseling.
- If you become unable to take care of yourself and additional help is required.
- In some cases if you are under the age of 18.

You should be aware that, except in the case of information given to a licensed psychologist, legal confidentiality does not apply in criminal or delinquency proceedings.

I am bound by confidentiality in the client-therapist relationship. That means I may not talk to anyone about our work together, including family members, unless I have your written permission, or you are under the age of 18 years. It should be noted that at 15 years of age a client can consent to his/her own treatment. There are exceptions to this mandated law as noted above. If you have seen another therapist or psychiatrist and that information would be helpful to your work with me, you must first agree to sign a written release before I may speak with this professional.

9. **Records:** Records include identifying information, dates of sessions, an initial assessment, treatment plan, and any consultations or collateral contacts made. Your records will be stored safely with attention to your privacy. They can only be released with your written permission and direction. I may sometimes summarize the content related to the request rather than release the entire record. You will not be given a photocopy of your record, but you will be granted reasonable access. If you choose to read your record, it is my policy to be present in order to respond to any questions or confusion you may have about the recordings.
10. **Termination:** Termination will usually be agreed upon mutually, however, you are free to terminate at any time. In rare instances, it may be in my best clinical judgment to terminate services despite your wish to continue. These instances can include: treatment goals have been met, a need for special services outside the area of my competency, and/or a failure to meet the terms of our fee agreement. Should this occur, the reason for termination will be discussed with you, and you will be helped to make different plans for yourself, including a referral to a more appropriate resource.

If you have any questions and/or concerns, please feel free to ask.

My signature below indicates that I have read the preceding information and understand my rights as a client and agree to abide by the terms specified in the document.

Client Signature

Date

Parent/Guardian (if client is under 15 years of age)

Date

Paul Fugelsang, MA, LMHC
Psychotherapist

Date

INFORMED CONSENT TO ONLINE TREATMENT

I have considered, understood, and agreed to the risks, benefits, and alternatives to the use of online communication in clinical work with my treatment provider, Paul Fugelsang.

I understand that every effort will be made to maintain the confidentiality of our communications. I understand that the clinician can guarantee the confidentiality of secure email/Skype exchange only on his end of the communication. I understand that no communication on the Internet can be guaranteed completely free from potential breach of confidentiality in transit by hackers or Internet service providers or by others who have access to the account or the computer.

I have been informed of circumstances in which online counseling or therapy is not the appropriate or most effective treatment. In the event of a medical, psychiatric, or other situation requiring face-to-face intervention, I understand that it is my responsibility to seek such help. I understand that information on nationwide crisis intervention and help resources in the United States includes the following:

www.hopeline.com
1-800-SUICIDE
1-800-656-HOPE
1-800-TLC-TEEN

If I reside outside New York State or Florida, I hereby confirm that I consider our meetings to occur in cyberspace and that the clinician does not claim to be licensed or credentialed in my state or country of residence. If my state of residence has laws regulating with whom I may seek counseling or therapy online, I am responsible for informing myself and complying with such laws. I accept full responsibility for my decision to work with the clinician under these conditions.

Client Signature

Date

Paul Fugelsang, MA, LMHC
Psychotherapist

Date