ARCADIA
Counseling & Consulting Services, LLC.

Tracey S. McCarthy, M.S.Ed., NCC, LPC

Informed Consent

This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I am licensed as a Professional Counselor in the Commonwealth of Pennsylvania. In addition, I am certified by the National Board of Certified Counselors, a private certifying agency that recognizes counselors who have distinguished themselves through meeting the board's standards for education, knowledge, and experience.

I hold a Master's (M.S.Ed.) degree in counseling from Duquesne University. The graduate program I completed is accredited by the Council on Accreditation of Counseling and Related Education Programs (CACREP).

I provide services for clients at Arcadia Counseling whom I believe have the capacity to resolve their own problems with my assistance. A counseling relationship between a professional counselor and client is a professional relationship in which the professional counselor assists the client in exploring and resolving life issues. The length of the counseling relationship differs for each client. Clients are in complete control and may end our counseling relationship at any time. In the event that you are dissatisfied with my services for any reason, please let me know.

The following are policies and procedures. Your signature at the bottom indicates understanding and agreement. Your signature does not bind you to any specific length of treatment.

1. **Consent to Treatment:** Client agrees to enter into treatment and understands that they may terminate treatment at any time.

2. **Confidentiality:** All client contacts will be kept confidential. Mandated legal and/or ethical exceptions are as follows:

    A. **Release of information agreements -** Arcadia will release information to third parties (insurance companies, EAPs, other agency personnel, family members, etc.) only at the client's request and after a release of information has been signed by the client. Session payment by someone other than the client does not entitle them to treatment information.

    B. **Regarding minors -** Arcadia adheres to the Pennsylvania Child Welfare Agency's legal duty to report any suspicion of neglect, physical or sexual abuse of minors.

    C. **Safety issues -** For any client determined to be at risk for harm to self or to others, Arcadia will follow all appropriate warning or reporting procedures to help ensure the safety of the client and/or others at risk.

    D. **Managed care -** For any client wishing to have us contract with their insurance company for authorized sessions, this constitutes agreement and understanding of the contents and nature of outpatient review forms and claims that must be submitted for continued treatment authorization, as well as permission to release.

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E. **Payment responsibility -** Failure to meet financial obligations will result in client's name, telephone number, dates of service and outstanding balance information being submitted for legal collection action. This will occur after ninety days of in-house collection attempts have been made. After 30 days, a 1.5% late fee will begin to accrue on any unpaid balance.

3. **Session Length:** Therapy sessions will be 45-50 minutes in length. Increased session length may be negotiated as needed and will be charged according to session fee. Please note that some insurance companies will only reimburse one 45-50 minute session per day. Increased session length will be billed as self-pay.

4. **Payment and Fees:** Payment in full is required at each session. Make all checks payable to *Arcadia Counseling*. Unless alternative arrangements have been made, or payment is being made by an insurance company, no more than two sessions may be conducted without payment. Payment will only be accepted from an insurance company after authorization is given and payment arrangements have been established. Client is responsible for payment of all co-pay, coinsurance or deductible charges, as well as any unpaid insurance claims.

5. **Returned (NSF) Check fee**: A service fee of $ 20.00 will be assessed on all returned client checks.

6. **Cancellations**: Twenty-four (24) hours' notice is required. Late cancellations or no-shows will result in a service fee in the amount of a full session. This is not an insurance reimbursable expense. Extenuating circumstances will be considered.

7. **Emergencies:** If my counselor is unavailable, my counselor will return my call as soon as possible. If I cannot reach my counselor, I can call 911 or go to the emergency room.

8. **Contact information:** Please indicate the best means to contact you:

Home: _____	May I leave a message?	Yes ___	No ___
Work: _____	May I leave a message?	Yes ___	No ___
Cell: _____	May I leave a message?	Yes ___	No ___
Email: _____	May I leave a message?	Yes ___	No ___

9. **Records:** You have the right to request to review any documents in your file.

I have read the above information and my signature below indicates my agreement and understanding of how the above applies to me.

_____ _____
Client(s) Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Counselor Signature Date