

INFORMED CONSENT

Thank you for choosing JSTtherapy, Jill Scott-Trainer, MSW, LCSW. Today's appointment will take approximately 60 minutes. Realizing that starting counseling is a major decision and you may have many questions this document is intended to inform you of policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and Jill Scott-Trainer will try her best to give you all the information you need. Jill Scott-Trainer, MSW, LCSW has earned a Bachelor of Arts Degree in Psychology from the University of Iowa and a Masters Degree in Social Work from Loyola University in Chicago. She is licensed by the State of Illinois as a Licensed Clinical Social Worker. She has over 15 years (10 years post masters) of clinical experience in treating adolescents, adults, and families using individual, family therapy, and group therapy. She specializes in adjustment to illness (new diagnosis, chronic, or terminal), grief and loss, relationship transitions, and anxiety. Jill Scott-Trainer practices standard cognitive behavioral therapy, family systems theory, solution focused, and psychodynamic therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and 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 designated psychiatrist (either referred by Jill Scott-Trainer or of your own), 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 Illinois State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and 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 h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, and I call is not returned within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Jill Scott-Trainer will follow 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 Jill Scott-Trainer will bill your insurance company, HMO, responsible party or third party payer for you if you wish. Jill Scott-Trainer asks that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds \$300.00 we will need to ask that you pay for services when rendered. 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. We ask that every client authorize payment of medical benefits directly to Jill Scott-Trainer.

I have received a copy of my fee schedule _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

You may have a copy of this form if requested.

Signature(s) _____ **Date** _____

COORDINATION OF TREATMENT: *It is important that all health care 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 inform will be shared.*

___ **You may inform my physician(s)** ___ **I decline to inform my physician**

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

Signature(s) _____ **Date** _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

Signature(s) _____ **Date** _____

*May we contact you at home (circle one) **yes no?***

*May we contact you at work **yes no?***

*May we contact you by cell phone **yes no?***

*May we contact you through email/texting? **yes no?***

Preferred method to contact you _____?

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that _____ maybe treated as a client by Jill Scott-Trainer, MSW, LCSW. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.*

Signature(s) _____ **Date** _____