Driftwood
Counseling Services LLC

Informed Consent & Counselor-Client Contract

NOTE TO THOSE USING EMAIL: Please read this contract and type your name in the signature line. Then email the contract back with the following in the body of the email: "I have read, understood and accept the terms of the client/counselor contract."

Thank you for choosing Driftwood Counseling Services LLC & Shelly Wiggins MA, LPC. Your 1st appointment will take approximately 60 minutes. 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, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

Qualifications/Experience

Shelly Wiggins MA LPC has earned a Bachelor of Arts Degree in Communications from Central Michigan University and a Masters Degree in Professional Counseling from George Fox University of Oregon. She has been licensed by the State of Michigan as a Licensed Professional Counselor since 2005. She has over 10 years of clinical experience from inpatient psychiatric, agency and individual private practice. Special training includes treatment for codependency, depression & anxiety disorders and eating disorders. Shelly has served individuals, pre-marital & married couples, families and groups with compassionate Cognitive Behavioral therapy for most conditions. Extensive training has been completed by Shelly in the areas of biblical principals in counseling & the treatment of eating disorders. 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 in 1st session.

Nature of Counseling

I accept clients from all cultural, religious and socioeconomic backgrounds. I myself practice Christianity, and although I do not use the counseling forum as an opportunity to impose my religious beliefs, I do encourage clients to develop spiritually. For clients that request it, I specialize in Christian counseling. I approach the counseling process holistically, urging clients to consider how physical, intellectual, emotional and social health impact psychological health. I assist clients in developing good health habits, conquering addictions, and correcting irrational thoughts and faulty relational patterns. The goal of my work with clients is that they learn skills that eventually enable them to help themselves.

Our communication will be very intimate at times, but it is essential that we both bear in mind that our relationship is professional, and social contact outside of the counseling relationship, if it happens at all, will be limited for the sake of preserving the quality of our therapeutic relationship.

Referrals

If you are at any time dissatisfied with my services, please tell me. If needed, I will assist you in finding another therapist that is more fitting for your personal preferences.

Fees, Cancellation, and Insurance Reimbursement

My fee is 210 for an initial session, and 120 for follow-up sessions. For clients without insurance or those with high co-pay, I use a sliding scale to make the sessions affordable. The fees are to be paid prior to session in cash, check or credit card. In exchange for this fee, I agree to provide services for you. Phone clients generally pay via pay pal account or may be billed on a monthly basis.

There is a $25 fee for bounced checks. I encourage clients to keep in touch with me via email; should email communications that you send become lengthy (more than 1-2 average paragraphs) I reserve the right to bill for the time spent reading and answering the emails.

I am unable to allow large back balances to build. If your account is more than 30 days in arrears and suitable arrangements for payment have not been made, I have the option of suspending or discontinuing treatment. In the event of termination, I'll provide referrals so that treatment can continue with another provider.

Because I'm a licensed provider, some insurance companies will reimburse you for all or part of the fees for counseling. I have a list of questions which I'll give you to ask your insurance company to aid in your understanding of your in-network and out-of-network benefits for mental health services.

Legal Issues

It is in your best interest to inform me of any litigation, dispute with employer, or separation or divorce issues you may have. In custody cases, I need signed permission from both parents. Remember that medical and mental health records are frequently subpoenaed when litigation is involved. It is not my practice to release any records unless there is a court order signed by a judge that I must due so by law.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

The nature of my counseling services is strictly outpatient. I cannot assume responsibility for your day to day functioning, as some more intensive treatments are designed to do. It is your responsibility to discuss expectations of after-hours care with me so that an appropriate referral can be made.

Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist, 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 Michigan 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, the client or guardian understands that they are to contact the local emergency room or call (911) for those services. Shelly Wiggins LPC will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____Date: _____

I understand my expected payment for counseling services and have received a copy of my fee schedule _____(initials)

COORDINATION OF TREAMENT: *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?***

What number is best to reach you _____*?*

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent, that _____ maybe treated as a client by Shelly Wiggins LPC. At times, it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide convenient & timely treatment for you and your children. I understand the need for confidentiality between my teenager and his/her therapist and that confidentiality will be maintained unless the therapist determines that my teenager is a danger to self or others.

Parent/Guardian Signature	Date

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the no show rate of $50. 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_____

By signing this form you are also consenting to enter into treatment and take responsibility for payment of this service. Please print & sign 2 copies of this form, keeping one for your files and returning the other to me. If you prefer to fax rather than email the forms the number to use is 989-288-4424. By your signature you indicate that you have read and understood these statements, and/or that any questions you have about these statements have been answered to your satisfaction.

Client Signature	Date
Client Guardian Signature	Date
Therapist- Shelly Wiggins LPC	Date