

Consent for Treatment Client Rights/Counseling Agreement

J. Morgan Grey, LPC, REAT
The Power Company
4625 S. Wendler Drive, Ste 111, Tempe, AZ 85282
602-391-3473 • thepowercompanyaz@gmail.com

Purpose of Treatment and Your Rights

Individuals engage in therapy for a variety of reasons. I consider you a partner in your care. When you are well-informed, participate in treatment decisions and communicate openly with your clinician or doctor you help make your care as effective as possible. Often therapy involves difficult aspects of life and you may experience uncomfortable feelings. Beneficial results depend on an active effort on your part. You have the right to participate in your treatment planning and be informed of all aspects of treatment decisions, development, review and revision of your treatment plan. You have the right to ask questions about anything that happens in therapy. You are free to leave therapy at any time.

My Approach to Therapy

In general my approach to therapy allows you to become more aware of your internal experiences and perceptions of the world and fosters a mutual observation of how it is that you support or limit your growth.

More specifically in therapy I may use any of the following modalities; movement, drawing, painting, sculpting, music, sound, writing, poetry, imagery, meditation, yoga, prana (breath work) and improvisational drama. I am likely to include dialog, interpretation, cognitive behavioral, insight, awareness exercises, visualization, journal keeping and reading suggested books or articles.

The benefits of this approach is the holistic nature of engaging physical, spiritual, emotional and behavioral aspects of self. I believe that it is through the creative process that we become informed, find insight and further our growth and development. If you would like to learn more about this approach, I have books about it that I can recommend to you.

Confidentiality and Personal Information

The law protects the privacy of all communications between patient and therapist and dictates how I manage your personal information. I may discuss your case with another professional for the sole purposes of supervision. In this event your name will not be made available to that professional.

I am required by law to report anyone whose life/health is at serious risk.

- This includes self-harm; If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team.
- This includes intention to harm others and/or information that an individual is at risk for being harmed. This includes abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

Record Keeping and Your Rights

I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record.

You have the right to a copy of your file at any time. You have the right to request that I make a copy of your file available to any other health care provider at your written request.

If you choose to correspond with me at anytime through the use of electronic media (e-mail) please be aware that there are risks and limitations to confidentiality that can not be maintained. Additionally, all electronic correspondence will be placed in your client file.

Appointments

Unless otherwise arranged, consultation sessions are scheduled for 50 minutes. Together we will agree on our frequency of meeting. A scheduled appointment means I reserved time only for you. If you miss your appointment or cancel with less than 24 hours notice, you will be charged a \$60.00 cancellation fee.

Financial Terms

You are responsible for paying for your sessions as agreed upon. Unless otherwise arranged, my fee is \$120.00 an hour. Services for time periods other than a usual appointment are charged proportionally. Examples include phone conversations, phone messages or e-mails requiring my review that exceed 10 minutes time for any given week.

Upon verification of insurance coverage and policy limits, your insurance carrier will be billed for your sessions. I will be paid directly by the carrier and you will be responsible for any deductibles and co-payments. If your insurance plan determines you are not eligible, you are responsible for full payment.

Payment arrangements should be finalized during your first visit.

In the event of default of payment, the balance is due in full. You will be responsible for any reasonable court costs, attorney fees and/or collection fees incurred. Your default payment will be sent to Collections after 3 months.

Contacting Me

Messages can be left for me at my office number; 602-391-3474. Messages are checked daily. Many therapists provide 24 hour access in case of emergency. I do provide after hour assistance when messages are received, but am not available 24 hours a day. If treatment requires frequent after hours assistance please request a referral.

Client Responsibilities

As a client you have the responsibility to:

- Provide information that I may need to plan your care needs.
- Follow out agreed upon plans and instruction for care.
- Learn about your problems and work with me to develop a plan for your care.
- Give at least 24 hours notice if you are unable to keep an appointment.
- Make your financial obligations

Consent to Treat

I authorize and request that Morgan Grey, LPC, REAT carry out behavioral health treatments and/or diagnostic procedures which now or during the course of my care are advisable.

I acknowledge that I authorize the use and disclosure of my information as defined.

I authorize payment of medical benefits to Morgan Grey, LPC, REAT for services rendered and I understand and agree to all of the above information.

I understand my rights and responsibilities as a client, and my therapist's responsibilities to me.

I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made .

I am over the age of eighteen.

Signed _____ Date _____

Witness _____ Date _____