INFORMED CONSENT

Counseling Relationship: A counseling relationship needs to function under professional guidelines for it to provide maximum benefit. To avoid dual relationship issues, our contact will be limited to counseling sessions or other professional concerns such as scheduling and/or emergencies. If there is contact in another setting, I will protect your confidentiality by allowing you to initiate any interaction that occurs. Session are 55 minutes in length for induvial and marriage counseling, unless otherwise agreed that they will last longer. Canceling a session at least 24 hours in advance is greatly appreciated and will prevent a cancellation charge of $50.00

Effects of Counseling: While benefits are expected from counseling, no specific outcomes are guaranteed. Part of the process is to establish goals and a plan for reaching them. Your time in counseling may lead to major changes in how you choose to view important issues in your life. The exact nature of these changes is not predictable and could affect significant relationships, your job and your view of yourself. During the counseling process there may be periods of increased discomfort and strong feelings. The intent is to facilitate the best possible outcome based on your goals for counseling. Counseling techniques will be tailored to your presenting issue.

Client Rights: The length of time in the counseling process varies depending on the individual. You are in complete control of your counseling and can terminate your counseling at any time. However, I ask that you participate in a termination session when that decision is made. At any time, you may refuse or discuss modification of any counseling techniques or suggestions. I am committed to providing my services in a professional manner consistent with accepted legal and ethical standards. If at any time you are dissatisfied with my services, please let me know.. If I am unable to resolve your concerns, we can consult with another counselor or I will help you locate another counselor to continue the counseling process. If you feel that any ethical violations have occurred, you may contact the Washington State Department of Health, Health Professions Quality Assurance Office at (360)236-4700.

Referrals: There may be times that I refer you to other professionals to provide services that will enhance our work. If you and/or I believe that a referral to another counselor is needed, I will provide you with the names of other counselors who may assist you. You will be responsible for contacting and evaluating those referrals as they may maximize the quality of your care.

Confidentiality: Most communication in the counseling relationship is confidential. However, the following limitations do exist:

- I determine that you are at risk of harming yourself or someone else. This may include impending suicide risk and /or from self-harm and requesting emergency assistance and transportation to a medical facility.
- You disclose abuse or neglect of a child, an elderly or disabled person.
- You disclose sexual contact with another mental health professional.
- I am ordered by a court or subpoena to disclose information or otherwise required by law to disclose information.
- You direct me to release your records. A Release of Information for will be used for this purpose.
- Your insurance or third party payer requests information to authorize coverage of services. A copy of any written report will be made available to the client.

The client agrees to hold the counselor harmless for the disclosures and consequences of sharing of information with third party payers.

Children over the age of sixteen are considered legal adults when involved in mental health service. Therefore, the same laws as adults govern confidentiality. Before the age of sixteen, communication of confidential information between counselor, client and parents or legal guardians is at the discretion of the counselor. In marriage and/or family counseling, I will keep confidential within the limits noted above. However, open communication among family members is encouraged and I reserve the right to terminate our counseling relationship if I judge the counseling process to be non-therapeutic.

Records: All records become the property of the office of Karen Larkin Packwood, MA, NCC, LMHC, CCTP, CDPT. I am certified as a Telemental Health Counselor and can conduct session via telephone, the internet and/or face-to-face. All records are kept for seven years and then properly disposed of.

By your signature below you are indicating that you have read and understand this Informed Consent and that any questions you had were answered to your satisfaction. By my signature I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications.

Client's Signature_____Date_____

Print Name_____

Counselor's Name_____Date_____