



Debbie Davis Counseling
Changing Your Tomorrow by Helping You Grow Today
Informed Consent for Counseling

Thank you for choosing Debbie Davis, LMHC. Today's appointment with me will take approximately 60 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and with best intentions I will either give you or direct you to get the information you need.

I have earned a Masters Degree in Psychology and Clinical counseling from the Troy University and a bachelor's degree in Christian leadership/education from Florida Christian College which is now Johnson University. I am licensed by the State of Florida as a Licensed Mental Health Counselor.

COUNSELING

Counseling is the process of resolving problems by talking with a person professionally trained to help people achieve a more fulfilling life. The process of change will be unique to you. This process begins by clearly defining the problem and mutually deciding on goals for therapy. You may be asked to supply personal information about yourself and your family that may include (but is not limited to) information about the family you grew up in, past events in your life, ways in which you communicate, your abuse history, and your substance use. I often use Christian concepts to guide in my efforts to assist you, but I will not impose my beliefs on you. I may suggest supplemental books to facilitate the counseling process. I use a variety of approaches and strategies to assist you in achieving your goals. These may include (but are not limited to) prayer, scripture reading, cognitive-behavioral strategies, family systems strategies, and/or solution focused strategies. I will make every effort to assist you in achieving your goals, but I cannot guarantee results.

CONFIDENTIALITY

All sessions are kept strictly confidential, meaning, I cannot share any information you give to me, including that you have been here for counseling, without your written permission (release of information form). By Florida Law, the following are the only reasons confidentiality may be broken: 1) Immediate danger to you or someone else, 2) Report of abuse or neglect of a child, elderly person or a disabled person, 3) Court order, 4) Report of unethical or illegal conduct by another mental health or medical professional. If any of these situations arise, we must give out enough information to try to keep people safe. If records are requested by you or by anyone else (including a court), a summary letter will be provided.

CLIENT RESPONSIBILITY AND RIGHTS

- You are expected to arrive on time for each appointment.
- You have the right to participate in therapy as well as terminate therapy at any time without penalty.
- You are expected to be free of substance abuse during therapy.
- If your issue requires an expertise I do not have, I will assist you in connecting to an appropriate resource.
- There may be times that I may confidentially consult with other mental health professionals regarding case management. This is to assure quality care while maintaining your identity.

- You may access available information regarding my professional license, credentials and access to the ethical guidelines or “standards of Practice” in Mental Health counseling. I am licensed under Florida Statute 491 of the board of Mental Health Counseling of the Agency of Health Care Administration in Tallahassee, FL. Informed Consent for Counseling.

CLIENT RECORDS

The purposes of your client file are to help provide you with the best service possible and to maintain a record regarding the type and quality of services provided. It will include intake paperwork, goals, progress notes, data received from any psychological tests, and information on appointments kept and cancelled. Records will be maintained in a secure manner and are only accessible to your counselor.

URGENT NEEDS

If you have a medical or life-threatening emergency, please call 911 immediately. If you have an urgent need to communicate with me, please contact me via phone at 904 307 8123. **Please note email correspondence is not considered confidential. At times I will be out of the office, or on vacation, during these times there will be someone to cover calls for me. This information will be provided to you when that need arises.

Fees: \$120.00 per 60-minute session

METHODS OF PAYMENT

Payment is made directly to me at the end of the session. Cash, checks and credit cards are accepted. Please make checks payable to: Debbie Davis Counseling

INSURANCE FILING

As this time, I am not in network with any insurance providers. I will be able to provide a superbill of services rendered for you to file your insurance should you have out of network benefits. You are expected to pay for services rendered at the time of service.

CANCELLATION POLICY

A 24-hour notice is requested for persons desiring to change or cancel appointments. Persons who miss a scheduled session without any notification or who call to cancel on the same day of their appointment will be charged a \$75.00 late cancellation fee of that session. Your cooperation in scheduling prevents others from being denied an opportunity to attend counseling. Please be considerate!

DISPUTES

Due to the requirements of licensure and personal responsibility, Debbie Davis adheres to the American Counseling Association’s Code of Ethics. While you are participating in counseling with Debbie Davis, should you have any reason to violate this code, you may contact the Florida Department of Mental Health Professions at (888) 419-3456 or (850) 414- 1976. You may obtain a copy of the Code of Ethics from the American Counseling Association at www.counseling.org or 1(800) 422-2648.

Thank you for choosing counseling with Debbie Davis, LMHC, LLC. I look forward to serving you.

Consent and Authorization for Treatment I consent to and authorize the assessment and/or treatment I will receive as a client of Debbie Davis, LMHC, LLC. I have read the policies of this office. I understand these rules and policies and agree to follow them.

_____ I would like a copy of this signed consent form for my records.

_____ I do not need a copy of this consent form.

Signature of Client

Date

Signature of Parent if client is a minor

Date