**Jessica Schild, LCSW**
415-390-5835
Reflect Counseling Services

# INFORMED CONSENT TO SERVICES:

I understand that the information of the person who is receiving counseling services is protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPPA). I understand that all information sent electronically (e.g. fax, email, mail) is confidential. The exceptions to confidentiality include:

- Intent to harm yourself or another: If you or your child states the intention to harm a reasonably identifiable victim, Jessica Schild is legally mandated to report it to that person and to the local police. If you have a serious plan to harm or kill yourself, or your child has a serious plan to harm or kill him/herself, confidentiality may be broken to ensure safety.
- Child Abuse: If there are disclosures of physical, sexual, emotional abuse, or neglect, Jessica Schild is legally mandated to call Child Protective Services (CPS).
- Dependent/Elder Abuse: If there are disclosures of elder abuse (i.e. neglect, financial abuse, physical abuse), Jessica Schild is legally mandated to call Adult Protective Services.
- Collections: If there is a lapse of payment for more than three months or more, your name may be given to a collections agency.
- A court of law may subpoena records.

_____Initials

For Parents & Guardians Only:

- Parents /guardians are encouraged to respect their minor child's right to confidentiality. Minors will be encouraged to share critical information but parents/guardians will only be given information regarding therapy themes and treatment progress. However, I understand that if Jessica Schild has reason to believe that my minor child is in danger of hurting him/herself, I will be notified immediately. _____Initials

- I understand that therapist, Jessica Schild is not conducting a custody or visitation evaluation for the child/youth. I agree not to involve the therapist in any custody or visitation disputes. I agree not to involve the therapist in court proceedings regarding any treatment of the child/youth now or in the future, nor will the therapist be asked to share the child/youth's records regarding any such proceeding. _____Initials

I hereby request and consent to services which includes therapy, diagnostic assessment, and the development of a treatment plan. I understand that developing a treatment plan with my therapist (or my child's therapist) and regularly reviewing our work towards meeting the treatment goals are in my (or my child's) best interest. I agree to play an active role in this process. If I am a parent or guardian of a child/youth receiving counseling services, I understand that an important part of therapy with a child or youth includes regular meetings with parents/guardians. _____Initials

I have been informed that any information regarding services with Jessica Schild are subject to release only by my informed and written consent or by subpoena and/or court order. I authorize Jessica Schild to release my DSM-V diagnosis code (or my child's) if it is necessary to process claims through my insurance for the services provided (insurance clients only). ____Initials

I understand that services are voluntary and I have the right to stop therapy at any time. If I choose to stop treatment for myself (or my child), I understand that I will be financially responsible for any services that have been completed. ___Initials

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**Client Rights:**

1. You have a right to ask questions and/or refuse any therapeutic technique or recommended treatment and the right to be advised of the consequences of such refusal or withdrawal.
2. You have the right to end therapy at any time out any moral, legal, or financial obligations other than those already accrued.
3. You have the right to participate in treatment decisions and in the development and periodic review/revision of your treatment plan.
4. You have the right access copies of your client and payment records. Requests must be made in writing. Jessica Schild may deny these requests if she is am concerned that:
    - It is reasonably likely to endanger your life or physical safety, or someone else's.
    - The records refer to another person and access is reasonably likely to cause substantial harm to them.
    - Access by your designated health care decision maker is reasonably likely to cause you or someone else harm.
    - Access would reveal information that I received confidentially from another professional and access is reasonably likely to reveal their identity.

*If Jessica Schild denies a request for access to copies of records, she will let you know why in writing.

_____Initials

**Fees and Payments:**
The fee for a standard counseling session is $150. Sliding scale fees are also available based on income. Please discuss these fees with Jessica Schild. Phone calls over 15 minutes and paperwork required/request by clients will be billed at the $150 rate per time of call. Any work related to legal situations (i.e. attorney calls, writing reports ad court appearances) will be billed at 250.00/hour (billed in 15 minute increments).

Cash and personal checks are accepted at this time. Returned checks will be charged a $25 fee._____Initials

**No Show and Late Cancellation Policy:**
A 48-hour notice is required to cancel an appointment. If you fail to call within that time frame, you will be charged $100 or the agreed upon individual session fee for sliding scale clients. In order for counseling to be successful, it requires regular attendance and consistency. Please also keep in mind that Jessica Schild is unlikely to be able to reschedule a therapy session only 48 hours in advance. For this reason, she encourages you to please call as soon as you know the appointment will need to be cancelled. _____Initials

**Therapist Availability and Emergency Procedures:**
This practice does not have the capacity to respond to counseling emergencies. Emergencies should be directed to 911 or to the local 24-hour crisis line at 1-800-309-2131. If you or your child has a psychiatrist, you should also contact him/her during behavioral health emergencies. Further, you may leave a confidential voicemail at 415-390-5835. Non-urgent calls are typically returned within 24 hours. _____Initials

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**CONSENT FOR TREATMENT OF MINOR:**

I authorize Jessica Schild, LCSW, to provide services for _____. I agree to participate in the therapy process as recommended.

**Please print and sign below:**

Client Name_____

Client Signature_____Date_____

(If applicable) Parent or Guardian Name_____

Parent or Guardian
Signature_____Date_____

Therapist Name Jessica Schild, LCSW

Therapist Signature_____Date_____

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# Credit/Debit Card Authorization Form:

***It is the policy of this office to keep a debit/credit card on file. You may pay by cash or personal check, but a card must still be kept on file.***

Name on Card:_____

I authorize Jessica Schild, MSW, LCSW, to charge my credit/debit card for professional services as follows:

- To charge my card $50.00 for each no-show or late cancellation (less that 24 hour notice). For clients utilizing a sliding scale fee, the agreed upon session fee will be charged if it is lower than $50.00. Card will be charged on the day of the late cancellation/no-show unless other payment arrangements have been made.

- The balance of fees not paid by the client 30 days after a written billing statement has been given to the client.

Type of Card: Visa Mastercard Discover American Express

Credit Card Number_____-_____-_____-_____
Expiration Date:_____
Zip Code associated with card:_____
CVV Number_____

Card Holder Signature_____
Date_____