INFORMED CONSENT

Linda M. Sutton MA LCPC 16335 S. Harlem Ave. Tinley Park, IL 60477

Thank you for choosing Linda M. Sutton, MA LCPC. Today's appointment will take approximately 45 – 50 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. Linda M. Sutton MA LCPC has earned a Bachelor of Arts Degree in psychology and a Masters Degree in counseling from Governors State University of University Park, IL. She is licensed by the State of Illinois as a Licensed Clinical Professional Counselor . Her degree concentration is in Couples & Family counseling. Her clinical experience has allowed her the opportunity to treat individuals, couples, and families. Linda practices standard Cognitive Behavioral therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for : (a) information that may be shared with a 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, sexual abuse or elder abuse; then, by Illinois 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. In the unlikely event that I am unable to provide ongoing services if coherently capable, I will provide you with a referral to another counselor. I will maintain your records in my possession for a period of 7 years. If an emergency situation for which the client or their guardian feels immediate attention is necessary, and I am unable to return a call within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Linda M. Sutton MA LCPC will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.*

Signature(s) _____Date:_____

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we will need to ask*

that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Linda M. Sutton MA LCPC. ***I have received a copy of my fee schedule*** _____
Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. 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***_____

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?*** *Where may we contact you* _____*?*

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that* _____ *maybe treated as a client by Linda M. Sutton MA LCPC. It is understood that children over the age of 12 have confidentiality protected by law. It is understood that parent(s) should play an active role in their child's treatment by participating in sessions voluntarily and/or when requested by therapist I ask for your cooperation to provide the best treatment for you and your child(ren). This consent to treat expires at the end of treatment or if revoked in writing.* ***Signature(s)***_____***Date***____