

Crossroads Counseling Center

CLIENT INFORMATION & CONSENT

*Crossroads Counseling Center – Chatham Presbyterian Church
1835 East Walnut Street, Chatham, IL 62629 Phone: (217) 483-1224*

This Client Information and Consent form is designed to provide you with information about the expectations you can have of your counselor or counseling resident and that he/she will have of you. It is intended that this information will enable you to make an informed decision regarding participation in the outpatient counseling services provided by Crossroads Counseling Center.

Credentials

Donna Thurston:

Master's Degree in Marriage & Family Therapy
Licensed Clinical Professional Counselor (LCPC)

Darcy Lovett:

Master's Degree in Mental Health Counseling
Counseling Resident

Therapeutic Approach

Crossroads Counseling Center is a professional counseling facility offering assistance based on Biblical principles and insights. Accordingly, services will not be denied on the basis of race, religion, ethnicity, disability, sexual orientation, or HIV status.

Trust and mutual respect between the counselor or counseling resident and the client are essential to encouraging meaningful change. In this context, the two parties systematically work toward the client's achievement of healthy thoughts and behaviors. While personal change can be difficult and although it takes time, change is truly possible.

Appointments & Cancellation Policy

Appointments will be scheduled directly with your counselor or counseling resident. If you would need to cancel or reschedule an appointment, please call the counseling center at (217) 483-1224 at least 24 hours in advance to avoid a late cancellation fee. Please be aware that if you are utilizing insurance coverage, your insurance company cannot be billed for missed appointments.

Note: Emergency situations will be taken into account.

Number and Length of Visits

The number of sessions needed to ensure the best therapeutic outcome depends on many factors and will be discussed with you during the counseling session. Each counseling session is scheduled for a length of 55 minutes.

Payment for Services

Payment for the counseling services provided should be made at the time of service unless alternative arrangements are made. Payment can be in the form of cash or check. Checks should be made payable to **Chatham Presbyterian Church**, according to the applicable fee agreement that is reached and signed by you and your counselor or counseling resident. Insurance coverage will be assessed and considered on a case by case basis. However, please note that services provided by the counseling resident are not eligible for insurance reimbursement.

Relationship

The relationship your counselor or counseling resident has with clients is intended to be a professional and therapeutic relationship. While the counselor and counseling resident care very much about their clients, it is imperative that this professional relationship be maintained. Therefore, the counseling relationship is limited to the scheduled and paid face-to-face sessions and brief phone conversations related to scheduling issues. In addition, to ensure that clients receive the most effective care, the counselor and counseling resident can neither hold a position of a friend nor have a social/personal relationship with any clients.

Confidentiality

The discussions had between the counselor or counseling resident and you as the client are considered confidential. Federal and/or State laws and regulations protect the confidentiality of the client records maintained by the counselor and counseling resident. Confidentiality will be kept, except in the following instances:

1. Prior written consent has been obtained.
2. In the event of an emergency, such information is needed by medical personnel.
3. Appropriate authorities will be informed if there has been alleged or stated harm, injury or neglect toward children, elderly, mentally handicapped, or physically handicapped persons.
4. An appropriate court order is issued to obtain information.
5. Appropriate authorities will be informed if, based on the professional judgment of the counselor or counseling resident, your conduct or verbal statements indicate that imminent danger of physical violence or other means will be used to cause serious personal injury or death to yourself and/or others (as required by Illinois State Law).

In addition, professional misconduct by a health care professional must be reported by other health care professionals. In such cases, related client records may be released to substantiate disciplinary concerns.

If a client is seeing a counseling resident, please be aware that, due to professional regulations, the counseling resident is required to receive supervision from a fully licensed counselor. Therefore, the counseling resident may discuss a client's case (for supervision purposes only) with his/her supervisor. However, the client's name will not be shared with the supervisor so as to protect the client's privacy and confidentiality.

By signing this information and consent form, you are giving your consent to your counselor or counseling resident to share confidential information with all persons mandated by law and regulation. You are releasing and holding harmless your counselor or counseling resident from any departure from your right of confidentiality that may result.

Duty to Warn

In the event that the counselor or counseling resident reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the counselor or counseling resident to warn the person in danger, to contact my parents (or legal guardian) if under the age of 18, and/or the following emergency contact, in addition to medical and law enforcement personnel:

Name of Emergency Contact:

Telephone Number:

Client Contact Information

I consent for my counselor or counseling resident to reach me by mail and phone at the following address and phone number. I will immediately advise my counselor or counseling resident if this information changes:

Address:

Telephone Number:

After-Hours Emergencies

In the case of an emergency in which you need immediate assistance, please call 911. For non-emergencies, you may leave a confidential message for your counselor or counseling resident on his/her office voicemail (217) 483-1224 and he/she will return your call as soon as possible.

Ownership of Client Records

In the event that your counselor or counseling resident ceases employment with Crossroads Counseling Center, dies, or is in some way incapacitated, the ownership of your client records will be transferred to a Licensed Clinical Professional Counselor on staff or within the area.

Risks of Therapy

Many people find counseling to be helpful but, it is not for everyone and results are not guaranteed. People may feel an increased amount of distress when they begin exploring their thoughts and feelings. While this is normal during the counseling process, it is important to discuss these thoughts and feelings during your sessions. The benefits of counseling depend on the efforts of you and your counselor or counseling resident and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

Consent to Treatment

By signing below, I as the undersigned client, voluntarily agree to receive counseling and authorize my counselor (Donna Thurston) or counseling resident (Darcy Lovett) to provide such services as appropriate. In addition, I understand and agree to participate in the planning of my treatment and that I may stop services at any time. Sufficient opportunity has been given to me to ask questions and seek clarification of anything unclear to me. By signing below, I acknowledge that I've read, understood, and agree to all the terms and information contained herein.

Signature of Client (or Parent/Legal Guardian, if under 18)

Date

Signature of Counselor or Counseling Resident

Date