Suzette Wasvick
Counseling Services, Inc

PO Box 763
280 Main Street, Suite 14
Hill City, SD 57745
Office: 605.390.8791

403 National Street, Ste 1
Rapid City, SD 57702
Office: 605.390.8791

Consent for Counseling Services

Counseling can have many benefits. It can help you learn more about yourself, resulting in better communication in your relationships, feel more connected to the important people in you life, create a sense of hope and direction, relieve feelings of frustration, depression, and anxiety. It can give you the tools to change your feelings, thinking and behavior to find the path that is better for you. You determine the nature and the amount of change you wish to make.

In counseling, sometimes major life decisions are contemplated, including decisions involving separation with families, development of other types of relationships, changing employment settings and changing lifestyles. The decisions are a legitimate outcome of counseling experience as a result of an individual's calling into question many of their beliefs and values. Furthermore, symptoms may be intensified and the emotional experience may be very intense at times. I will be available to discuss any of your assumptions or possible negative side effects in our work together.

Your signature on page two of this document indicates your permission for you. We will decide as a team, when/if family therapy is a better option to meet your child/family's needs.

I am required by law to maintain records of each time we meet or talk on the phone. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. If you choose to file for insurance reimbursement, I have to assign you a diagnosis. If you have any questions about this, please let me know.

With very few exceptions, the information discussed during counseling sessions and all documentation (written or in other medium) is kept private and confidential. Some very important exceptions to this rule are:

- If there is a court order for the therapist to appear, or to produce the client's chart.
- If your insurance company is involved, some information will be given after you sign the release of information part of the insurance form.
- If the therapist learns that there exists a serious threat to any person, including you.
- If the therapist feels the need to collaborate case staffing with interoffice mental health providers. You may opt out by providing written notice.
- If there is evidence of suspected child, dependent adult or elder abuse.

Sessions are typically 50 to 60 minutes long. Longer sessions can be scheduled if we agree that it will be helpful. Please note, that there may be an extra charge for longer sessions and that most insurance pay the same amount regardless of the length of session.

On occasion there may be a need to have contact outside the normal counseling session. For your convenience, you can contact me through text, phone, or email. If I am not available to take your call of if it is after hours, please leave a voicemail message and I will get back to you

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within 24 hours, excluding weekends and holidays. If you have an emergency please call 911 or the Crisis Care Center at 605-391-4863.

My standard fee is $220.00 for the initial session and $200.00 per individual or family session. Teletherapy is billed as a regular session and may not be covered by insurance. Cash, check, or credit card payments are accepted. Clients will be charged an appropriate fee for any professional time spent responding to information requests as well. A 30-day notice will be given of any changes to fees.

I am an In-Network provider with some insurance companies. If I am an In-Network provider with your insurance company I will submit/file insurance claims. Although I am willing to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided. The client is responsible for full payment of my fees. Please know that for the sake of determining insurance coverage, the services rendered will be Outpatient Mental Health, and my license is LPC-MH2264. Please discuss any questions or concerns you may have about this with me.

I will be reserving time for you, so please give 24 hours notice, if you are not able to make your appointment. You may leave a voice mail, text, or email to cancel or reschedule your appointment. A fee will be charged if cancellation is less than 24 hours in advance.

Your participation in counseling is voluntary and you have the right to end therapy whenever you want. Should you decide to end counseling prior to a planned outcome, I encourage you to talk with me about the reason for your decision in a counseling session together. I may request that you allow for one final session for us to have an ending together, to review what we've done and to offer feedback to each other. Likewise, at my discretion, I reserve the right to end our therapy work together and provide you with some appropriate referrals for reasons including, but not limited to, failure to participate in therapy, conflicts of interest, untimely payment of fees, or my belief that I may not be the best person for your needs.

Consent for Services Signature

I/we have read, understand and agree to the information and policies described in the Informed Consent Form.

I/we have read, understand and agree to the cancellation policy.

Print Name of Client/Guardian: _____

Signature of Client/Guardian: _____ Date: _____

Print Name of Client/Guardian: _____

Signature of Client/Guardian: _____ Date: _____

Suzette Wasvick LPC-QMHP Signature:_____

Date:_____