Juniper Campbell, LPC, CCTP

Consent for Treatment, Adult

I understand that I will be engaging in psychotherapy with Juniper Campbell, LPC, a Clinically Certified Trauma Professional. This treatment aims to increase personal awareness, wholeness, personal responsibility, and acceptance to make changes so that I feel better or resolve specific life or adjustment problems that have caused me to seek assistance. The primary procedure used by Ms. Campbell is “talk” therapy, although I understand that she may also provide general education about behavioral health conditions or coping strategies. She has specialized training in Cognitive Behavioral Therapy, Person-Centered Therapy, EMDR, Somatic Therapies, and Equine Therapy. Using some of these techniques may require that I sign additional Consent for Treatment documents. I have had the opportunity to ask questions about any of the methods used by Ms. Campbell.

The potential benefit of treatment is that I will feel better about my life. There may be a reduction in my distress, increased relationship satisfaction, greater personal awareness, insight, or improved skills for managing stress. I understand that there are no miracle cures. Although therapy begins with the hope that my life and relationships(s) will improve, there is no guarantee that this will occur. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on intense emotions such as sadness, anger, guilt, frustration, or anxiety. I may feel worse or experience emotional pain in my relationships. I understand that psychotherapy will require a very active effort on my part and that for it to be most successful, I will have to be open and honest and need to work on things we discuss outside of sessions.

I understand that all information I share will be confidential, but this confidentiality is not absolute. In the case of a medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, or under court order, clinical information may be released. If an insurance company pays for my treatment, Ms. Campbell will release clinical information to my insurer as needed. In such cases, only the information required for reimbursement will be released. I have been provided with both a Notice of Privacy Practices required by the Health Insurance Portability and Accountability Act (HIPAA) and a document called “Additional Information About My Practice,” which addresses confidentiality in more detail, and I have had the opportunity to have any questions answered.

I understand that Ms. Campbell is an independently licensed professional counselor. However, to provide services that reflect best practices, she has contracted with Laurie Verdier to provide consultation/supervision. Ms. Verdier's phone number can be provided upon request if I have questions. In addition, she occasionally consults with various experts and peers. I understand that the same rules regarding confidentiality bind Ms. Verdier and any experts or peers as Ms. Campbell.

I understand that I can receive a copy of my records or have a copy of my records provided to another person by completing a Release of Information form and that a fee may be charged for this service. I understand that I have the right to participate in treatment decisions and that Ms. Campbell and I will together develop and periodically review and revise a treatment plan which will identify my treatment goals and the means of achieving those goals. I understand that I have the right to refuse any recommended treatment and may withdraw my consent to treatment at any time with any consequences clearly explained to me.

I understand that payment is due at the time of service unless other arrangements have been made. Ms. Campbell's current fee for self-pay sessions is $150 for the intake session and $135/hour for additional clinical sessions. She reserves the right to change fees with 30 days' notice. Payment may be made via cash or check. A $25.00 service charge will be incurred for any checks returned for any reason. **Late cancellations** (<24 hours) **or No-Show will incur a fee of $80,** although Ms. Campbell may waive this fee at her discretion. I understand that insurance companies do not pay for missed appointments. **Initials**____

You are responsible for coming to your session on time. If you are late, the therapy session will still end at the regularly scheduled time. Extended sessions, telephone calls over 15 minutes, report writing and reading, attendance at meetings with other professionals I have authorized, and time spent performing other services I have requested will be charged at the rate of $33.75 per 15-minute increments. If I cannot afford the fee for psychotherapy, I can talk with Ms. Campbell about the possibility of a hardship discount.

The cost of therapy services is my responsibility. If I am using insurance, I understand that I am responsible for all payments if my insurance does not cover services. I am also responsible for any deductibles or co-pays my insurance company requires. If I need to pay privately, Ms. Campbell will provide me with a coded receipt/Superbill that I may choose to submit to my insurance. I understand that submitting the Superbill to my insurance is not a guarantee of payment. If I am a private pay client, I will receive a Good Faith estimate at the beginning of my session. I understand that I am responsible

for all payments if my insurance does not cover services. I understand that unpaid balances past due over 90 days may be referred to a collection agency.

Initials____

Once you are placed on the schedule for a standing weekly appointment, it is expected that you will honor that agreed-upon scheduled time. If you miss three scheduled appointments, your appointment time will be forfeited and scheduled based on week-to-week availability. **Initials**____

I understand that unless other arrangements have been made, my case will be closed if I do not see Ms. Campbell for 30 days. Should this occur, I can return for a new Episode of Care, but in such a case, I will have to sign a new Consent to Treat and review the Treatment Plan to determine if goals remain the same or if a new Treatment Plan needs to be developed.

I have read the above information and consent for treatment. The HIPAA Notice of Privacy Practices is incorporated by reference into this document, as is the "Additional Information About My Practice."

Name Printed:_____

Signature: _____ Date:_____

Therapist:_____ Date:_____