Prevail Consulting LLC
Counseling Agreement/Informed Consent

Welcome to Prevail Counseling LLC. This document contains important information regarding office policies, your rights and expectations. Please feel free to discuss any questions you may have about any of the information below with your therapist, Elaine M. Grubb, MEd, LPCC, LICDC.

Confidentiality

The information (both verbal and written) that you share in counseling is confidential. I will not release information without your written permission, or that is a legal guardian's. Exceptions to confidentiality include:

- **Legally:** As a Licensed Counselor, I am mandated by law to report: **(1)** If I believe you are in imminent danger of harming yourself. **(2)** If I believe you will harm another person. **(3)** If I believe a child or vulnerable adult is being abused or neglected. **(4)** If you admitted to me that you have been exposed to controlled substances that are potentially harmful while being pregnant.
- **Couples Counseling:** If you are engaging in couples counseling there may be times when individual sessions become part of the process. What you say in those individual sessions will be considered to be part of couple's therapy and can be discussed in our joint sessions.
- **Family and Group Counseling:** Clients engaging in family and group counseling are obligated to respect the confidentiality of others. While such confidentiality is expected, it cannot be guaranteed and secrets cannot be kept from others involved in your treatment.
- **Minors:** When working with your child/adolescent, I maintain their confidentiality as a part of their therapeutic process as I would any adult client. Parents of clients under the age of 18 do have the legal right to examine their child's treatment records and therefore clients under the age of 18 cannot be assured of unconditional confidentiality from their parents. If a parent desires such information, the request must be made in writing and a recommendation made on clinical judgment to move forward with such a request will be discussed in consultation with the parents.
- **Cell Phone Communication:** Cell phones can be intercepted by third parties. If cell phone communication, including texting, is utilized outside of scheduled sessions, confidentiality cannot be assured and your therapist is not responsible for any information intercepted by third parties.
- **Email Communication:** Emails cannot be assured of confidentiality and therefore your use of such forms of communication constitutes implied consent for reciprocal use of electronic mail.
- **Legal Procedures:** As your therapist, protecting your confidentiality is very important to me. I do not make a practice of testifying in court and if you are in need of a therapist for forensic reasons, I can refer you.
- **Insurance Providers:** Insurance companies and other third party payers are given information that they request regarding services to their clients.

Additional exceptions to confidentiality and uses/disclosures of Protected Health Information such as uses for insurance benefits, billing, or in the case of legal proceedings can be found in detail in the *Notice of Privacy Practices* and *Clients Rights Statement*. Information that may e requested includes, but is not limited to: types of service, dates/time of service, diagnosis, treatment plans, description of impairment, progress of therapy, case notes, and summaries.

By signing below, I acknowledge I have read and understand the above guidelines of confidentiality. I have been given the opportunity to read and/or received a copy, read, and understand the *Notice of Privacy Practices* and *Clients Rights Statement*.

_____ _____ Date: ___ /___ / ___

(Signature of Client) (Print Name)

_____ _____ Date: ___ /___ / ___

(Minor Client: Signature of Parent/Legal Guardian) (Print Name)

Contacting Me/Emergencies

I am not always immediately available by phone. If unavailable, voice messages are monitored and I will make every effort to return your call within 24 hrs. of the day you made it, with the exception of weekends and holidays. Prevail Counseling is not a crisis center. If you are experiencing a life threatening emergency and/or feel that you need immediate attention please call Netcare (614) 276-2273, 911, or go to your nearest emergency room.

Therapeutic Relationship

A therapeutic relationship is one that works in part because of clearly defined boundaries, rights and responsibilities of both therapist and client. This framework helps build a strong, therapeutic relationship is important to our work together. Therefore, ethical standards require that your therapist not engage in an outside personal or business relationship with you. At times we may happen to see each other in a public or social setting. If this occurs, I will not initiate communication or social interaction in order to protect your confidentiality.

Consultation

While I work individually in private practice, I do not work in isolation. To provide quality care and maintain standards of practice, I consult with other mental health professionals. Client's identifying information (such as name, employment, and contact information) is kept confidential during professional consultation.

Appointments

Your initial assessment appointment will average 60 minutes in length. Subsequent therapy sessions are 45 minutes in length (unless scheduled differently with your therapist to meet identified clinical needs). Please arrive on time. Your therapist makes efforts to stay on schedule for your appointment. If you are late for your appointment, please understand that we will conclude at the originally scheduled time.

Treatment and the Therapeutic Process

Therapy services begin with an evaluation of your needs. After completing an evaluation, we will discuss how our work together will proceed, and begin to develop a plan for treatment incorporating your goals for counseling. There are different treatment methods we may use to help with the difficulties you wish to address. As therapy progresses, you may find your goals change. We will regularly review your progress and facilitate adjustments in goals and/or treatment modalities as needed.

The therapeutic relationship is a collaborative one, thus, we will work together to meet your goals. However, the responsibility for taking action and making choices that initiate change is yours and calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and in-between sessions.

The counseling process can have benefits and the potential for emotional risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. It is important that you consider carefully whether these risks are worth the benefits to you of changing.

Most individuals who take these risks find that therapy can be helpful and often leads to better relationships, solutions to specific problems, a decrease in harmful behaviors, improved self-image and confidence, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience or that treatment will give you the results you are seeking. Please feel free to discuss any questions or concerns you may have at any point during treatment.

Eating Disorder Treatment

If you are seeing me for help with an eating disorder, I may recommend that you also work with a dietician and/or physician. Referrals can be provided if needed.

Termination

You are free to stop therapy at any time. If you make the decision to terminate services, it is appropriate to meet for a final session. If at any time you feel you are in need of additional services or an alternate therapist, a referral will be made to fit your needs. If after the initial interview appointment or at any time during the course of treatment, in my judgment, I feel I am unable to meet your needs, I will inform you of this and an appropriate referral will be provided.

Agreement

I have read (or have had read for/to me) and understand the information outlined in this document pertaining to confidentiality, emergency contact, therapeutic relationship, consultations, appointments, counseling process and termination. I have had all of my questions answered fully. My signature below indicates my agreement to comply with the above policies and procedures and to participate in therapy.

_____	_____	Date: ___ /___ / ___
(Signature of Client)	(Print Name)	
_____	_____	Date: ___ /___ / ___
(Signature of Client)	(Print Name)	
_____	_____	Date: ___ /___ / ___
(Signature of Parent/Legal Representative)	(Print Name)	
_____		Date: ___ /___ / ___
(Therapist Signature)	*Elaine M. Grubb, LPCC*	