

2850 45th St Suite B

Highland, IN 46322

Phone (219) 923-2050 Fax (219) 923-2151

**INFORMED CONSENT**

Thank you for choosing **Jennifer Willhoit, LCSW**. 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. Jennifer Willhoit, LCSW has earned a Bachelor of Psychology Degree in 1997 from Purdue University and a Master of Social Work from Indiana University in 2002. She is licensed by the State of Indiana as a Licensed Clinical Social Worker. She has over12 years of experience in treating adolescents, adults and families using individual and family therapy. 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: with our staff a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Indiana State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency arises for which the client or their guardian feels immediate attention is necessary, please contact me at 219-545-1805. If your call is not returned within 15 minutes, the client or guardian understands that they are to contact the nearest emergency room or community (911) for those services*. Jennifer Willhoit, LCSW *will follow those emergency services with standard counseling and support to the client or the client's family. It should be noted that Jennifer Willhoit, LCSW, will not respond to text messaging and that her personal number should ONLY be used in the case of an emergency.*

***Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**FINANCIAL/INSURANCE ISSUES:** *It is the client’s responsibility to know your specific insurance plan benefits. 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. If 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* Jennifer Willhoit, LCSW.

*(turn page)*

***I have received a copy of my fee schedule \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please initial) \* If you would like a copy of the fee schedule, please ask at the front desk.***

*Lastly, if you need to cancel or reschedule an appointment, please give* ***24 business hours*** *advance notice, otherwise you will be* ***charged $50.00****. 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 information 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. If you would like a copy of any documents, please ask at the front desk.*

*\** You have a right to see your record, but I have the right to limit that access if I believe there is compelling evidence that seeing parts of your record could cause you harm. Request for copy of file must be made in writing.

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?*

*Revised 08/01/2021*