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Informed Consent to Treatment

1. I will be given a clear description from my mental health provider regarding the problems, diagnosis, personal strengths/limitations and treatment interventions proposed.
2. I will be given a clear recommendation for the types of treatment recommended, such as individual counseling/therapy, group counseling/therapy, family/couples counseling/therapy, addictions counseling, and/or psychiatric services. Times, dates, and session length will be discussed with my mental health provider.
3. I voluntarily agree to undergo mental health treatment and understand that I may end treatment at any time. I understand that my mental health provider may want to discuss this with me, but that I reserve the right to stop treatment. Furthermore, I understand that my mental health provider may make diagnostic and treatment recommendations with which I may not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.).
4. I understand that my mental health provider cannot guarantee results (e.g., less depressed, improved marital satisfaction, etc.) of mental health services. However, there will be clearly stated reasons, goals, and objectives for continuing/discontinuing mental health treatment. This will be discussed with my mental health provider.
5. I understand that there may be some risks in participating in mental health services. These may include, but are not limited to, addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; re-uniting with family members; or being inconvenienced due to costs/fees of counseling. I am aware that I can discuss any unforeseen risks vs. benefits with my mental health provider at any time. In the case of psychiatric care, medications, side effects, and alternative treatments will be discussed.
6. I understand that I have the right to an interpreter (sign or language) if necessary.
7. If an emergency of a life-threatening in nature, my mental health provider will discuss how to access emergency services.
8. I understand that if I have a grievance with my mental health provider, I will communicate this directly to Dr. Lawrence
9. I understand that this "Informed Consent/Limits of Confidentiality Form" is not intended to be "all inclusive" of aspects of my mental health treatment. It is only intended to provide some useful information before deciding to engage in mental health treatment.

Limits of Confidentiality

I. The information that you share with your Mental Health Provider is considered to be confidential. In most cases, information cannot be released to another party without your written consent. However, in certain circumstances, information can be shared legally without your permission. These circumstances include:

1. Suicide: if you are assessed to be a danger to yourself; cannot guarantee your physical safety against the intention of suicide; and/or have immediate suicidal plans, this information is not considered to be "confidential". Actions may be taken to ensure your safety.
2. Homicide: if you are assessed to be a danger to others; cannot guarantee their safety; and have immediate, specific plans to cause fatal injury/harm to another person, this information is not considered to be "confidential". Actions may be taken to protect the safety of others. The police may be notified of your intentions as well as the intended victim.

3. Court order/subpoena: Your Mental Health Provider(s) can be required to relinquish a copy of your written Mental Health Record to the appropriate Courts. Mental Health Providers can also be subpoenaed to testify in court without your consent.
4. Child abuse/neglect: Arizona Law requires your Mental Health Provider to report to the appropriate authorities (i.e. Child Protective Services) any suspicion or evidence of child abuse or neglect. This law also applies to past incidents of abuse or neglect.
5. Elder abuse/neglect: Arizona Law requires your Mental Health Provider to report to the appropriate authorities any suspicion or evidence of elder abuse/neglect.
6. Laws regarding minors in mental health services: certain information may be shared with parent/legal guardians at the discretion of the mental health provider(s).

II. Mental Health confidential information may also be used in a number of ways without written permission. However this would never include any identifying information about you. It would be solely for the purpose of for coordinating services and delivering quality care. You may be informed if this is the case. These may include:
1. Consultations and case conference with other providers
2. For billing purposes: a diagnosis is given to your insurer for reimbursement purposes.

III. Other Notes on Your Privacy & Billing/Fee Information:

1. Video and audio taping: occasionally, If Dr. Lawrence would want to make an audio/video recording of your sessions. Your written permission is required. YOU HAVE THE RIGHT TO REFUSE THIS.
2. Generally, you will be contacted by phone. Internet email is discouraged unless discussed with your therapist. PLEASE NOTE: PRIVACY AND CONFIDENTIALITY OVER THE INTERNET CANNOT BE GUARANTEED.
3. I have discussed my insurance coverage and understand that I am responsible for payment and that Dr. Lawrence does not bill insurance. However, I understand that, if I have an "out of network benefit" with my insurance company, Dr. Lawrence will provide me with a "superbill" that I may submit to my insurance company, in order to obtain reimbursement.
4. I understand that it is Dr. Lawrence's policy to charge $145 for the first intake visit, $135 for subsequent visits and a $135 "no-show" fee in the event that I do not call to cancel an appointment with 24 hours notice. I understand that Third party reimbursers do not cover this fee and that fees for late cancels will be my responsibility. It is recommended that fees be paid at the time of service rendered. I understand that in the event that I do not receive a statement from Dr. Lawrence, I am still responsible for the charges incurred.

I have reviewed this "Informed Consent to Treatment/Limits of Confidentiality" information with my mental health provider.

I have been given the opportunity to ask questions about this information. A copy of this information is available upon request. By signing this, I indicate my understanding of this information.

Client Signature _____Print_____ Date _____

Client Signature_____Print_____ Date _____