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**Ashley Mangus Counseling Services, LLC**

**MSW, LCSW**

**300 East Main St., Suite C**

**Carmel, IN 46932**

**INFORMED CONSENT**

Welcome to the office of **Ashley Mangus Counseling Services, LLC/ New Beginnings Family Counseling, LLC.**  This document contains important information about your therapist’s professional services and business policies. We believe that by being well informed you can achieve the most optimal counseling outcomes. **Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting.** When you sign this document, it will represent an agreement between us. **Therapy cannot be initiated until your consent to treatment has been received.**

1. **COUNSELING/THERAPY SERVICES**

Therapy is a relationship between people that works in part because of the clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to create change. As a client in therapy, you have certain rights and responsibilities that are important for you to know about. There are also legal limitations to those rights that you should be aware of. As your therapist, I have corresponding responsibilities to you. These respective rights are described in the following sections.

Counseling is not easily described in general statements. It varies depending on the personalities of the counselor and patient, and the particular problems brought forward. There are many different methods I may use to deal with the problems that you hope to address and those methods will be tailored to each client for each situation. Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to attend sessions regularly and work on things we talk about both during our sessions and at home.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have many positive benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, personal insight and awareness that lead to positive changes and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include, my estimate of duration of therapy, and goals for sessions to follow, if you decide to continue with therapy.

You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very selective when choosing a therapist. You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You have the right and responsibility to choose the services and clinician that are best for you. **If you ever have concerns regarding therapy sessions, I welcome you to address those in session and I will work to resolve any concerns you might have.**

**2) TERMINATION OF THERAPY SERVICES**

**You are free to terminate therapy at any time and for any reason**. Should you decide to terminate therapy, it is most helpful if this is discussed in advance with the therapist so there can be proper closure, including any referrals when appropriate. In the majority of circumstances, you will be the one to determine when therapy should end. There are exceptions to this policy, however: If I am not able to help you because, in my judgment, my training and skills are not appropriate for the issues that bring you to therapy, I will inform you of this fact and refer you to another therapist who has the expertise to better meet your therapy needs and goals.

I am ethically bound to terminate therapy when it is reasonably clear that you are no longer benefiting from the therapy. If this is evident, I will discuss this with you and aid you in transitioning to a more appropriate referral source that might better assist you in meeting your therapy goals, or if your therapy goals have been met, I will aid in the smooth transition for purposes of closure. If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. Again, if I terminate you from therapy, I will offer you referrals to other sources of care to assist you in transitioning to another provider.

When the client is a minor the parents or legal guardian have the right to speak for the minor.

**3) Educational Background/Professional Experience**

I obtained my Masters of Social Work (MSW) in 2013 from Indiana University. I have passed the AWSB National Licensing Exam, giving me the credentials as a Licensed Clinical Social Worker (LCSW) in the state of Indiana. As an undergraduate, I studied Family Science from Brigham Young University receiving my BS in 2003.

My professional experience and training/expertise is working individuals, couples and families, in a variety of specialty areas, including depression, anxiety, trauma, communication issues, conflict resolution, infidelity, identity issues, grief/loss, sexual abuse and other major life transitions. In addition, I have focused my educational studies on women’s mental health.

**4) THERAPEUTIC APPROACH AND CODE OF ETHICS**

I am a family systems therapist, meaning that regardless of whether I am working with an individual, couple, or family, I am looking at how the entire family system works together. I am eclectic in my approach to working with clients. My primary theoretical orientations include: Family Systems Therapy, Cognitive Behavioral Family Therapy, Structural & Strategic Family Therapy, Narrative Family Therapy, and Acceptance and Commitment Therapy. When working specifically with couples, I generally utilize concepts from the Gottman Method of Therapy and Emotionally Focused Therapy. I will also use other orientations based on the needs of the client.

I adhere primarily to the NASW Code of Ethics.

**5) APPOINTMENTS/SCHEDULING/CANCELLATION POLICY**

I normally conduct a 50—minute initial assessment and evaluation. My primary objective is to get to know you and to gain a full understanding of the presenting issue. This includes gathering a personal and relational history and answering/asking questions you and I may have. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Once therapy has begun, I will schedule subsequent 50-minute sessions per week, based on your needs and therapeutic goals. We will collaborate together regarding the frequency and times we meet, recognizing that for some clients, sessions may be longer or more frequent.

The time scheduled for your appointment is assigned to you and you alone. If an appointment is cancelled or rescheduled **you are required to provide more than 24 hours advance notice of cancellation.** **If you miss a session without cancelling or cancel without 24 hours notification to me, you will be responsible to pay the full fee for that session.** If you or your child become ill, please notify me as soon as possible, no later than 4 hours prior to appointment times. In addition, you are responsible to come to your session on time and at the time scheduled.

If you are late for an appointment, your appointment time will still end at the end of the designated 50 minutes. Sessions will be 50 minutes unless prior arrangements are made, and should start and end promptly as a courtesy to both you, as the client, as well as others who are waiting for a session following your appointment. It is the client’s responsibility to end the session at the 50 minutes. Sessions going over the 50 minutes will be charged accordingly.

**6) PROFESSIONAL FEES/ PAYMENT**

**My hourly fee is $100 for a 50-minute initial session, and $100 per clinical hour**. A clinical hour **includes 50 minutes of face-to-face time and ten minutes for documentation and preparation** outside of the face-to-face time. I also charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, emails taking longer than 5 minutes to read, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

**Session fees are due at the time of service**, and may be made via cash, credit card, medical/flex spending or health savings account (if provided through a major credit card company), or personal check. There will be a $25 return check fee if your check is returned to my bank in addition to the check amount. I reserve the right to turn unpaid accounts over to a collections company after 90 days.

**8) INSURANCE**

I am not currently a panelled insurance provider. I accept cash, checks, HSA payments, VISA, MC, and other major credit cards.

**9) PROFESSIONAL RECORDS**

I am required to keep appropriate records of the therapy services that I provide. Although therapy often includes discussions of sensitive and private information, normally very brief records are kept noting that you have been here, what was done in session, and a general mention of the topics discussed. These records are for your clinical file and cannot be released to anyone without prior written notice by you. You have the right to request a copy of your clinical file be made available to you or any other health care provider at your written request. Your records are maintained in a secure, locked location in the office.

**10) CONFIDENTIALITY**

With the exception of the circumstances described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

You are protected under the provisions of the **Federal Health Insurance Portability and Accountability Act (HIPAA)**. This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my Internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

**The following are a list of reasons I would ever break confidentiality.**  I would inform you of any time when I think I will have to put these into effect.

\***PLEASE INITIAL that you have read below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or appropriate officials to protect your welfare. I am not obligated to explore all other options with you, but I would make every attempt to do so before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call as stated above.

4. In response to a court order or where otherwise required by law.

**11) “NO SECRETS” POLICY**

The following information is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in couple’s therapy with me. If you and your partner decide to have some individual sessions as part of the couple’s therapy, what you say in those individual sessions will be considered to be a part of the couple’s therapy. This means that what is said in these individual sessions can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner*. I will remind you of this policy before beginning such individual sessions. If anything is discussed during individual sessions that need to be addressed during couple’s therapy, I will give you the option of bringing it up prior to addressing it in couple’s therapy, in order to provide a safe environment for you to share openly.

The same “no secrets” policy extends to my work with families, as well. When working with a family, I consider the “family” to be the client. If one member of the family takes part in individual sessions as part of the family work, your confidentiality is generally going to be protected and respected. However, if there is information that, in my clinical judgment, is an important and necessary part of therapy with the family, to effectively serve the family unit, it may be important for this information to be shared with the family. I will use my best judgment in this, and will give the individual the opportunity to make this disclosure first (or I will assist you with this in a session). Additionally, I will remind you of this and review this policy prior to doing individual work as part of family therapy. If you feel it

Necessary to discuss matters that you absolutely do not wish to have shared with anyone in the family unit as a part of family therapy, you can ask me for a referral to an individual therapist who can work with you and I will assist you with this.

\***PLEASE INITIAL that you have read below:**

If you are in full agreement to this “No Secrets” Policy, please initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12) SUPERVISION**

As a therapist, the Indiana Department of Professional Regulations and the Indiana Licensing Board, as well as my professional association, require that therapists seek supervision for continued learning and educational purposes, as needed. This means that I am required to consult with a Licensed Clinical Social Work (LCSW) Supervisor, as well as my professional colleagues, as part of my practice for mutual professional consultation. Please initial below that you understand the following regarding supervision of your therapeutic services:

\***PLEASE INITIAL that you have read below:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your name and unique identifying characteristics will not be disclosed.

The supervisor/professional consultant(s) is also legally bound to keep the information confidential.

**13) CONTACTING ME**

I am often not immediately available by telephone. While I am usually in the office during normal business hours, **Monday, Tuesday, Wednesday & Thursday**, I do not answer the phone when I am with a client. If you need to reach me between sessions, you may leave a message on my confidential voicemail at **(801)-473-3707** at any time and your call will be returned as soon as possible or by the next business day under normal circumstances.

**14) EMERGENCY SERVICES**

Emergency services are not readily available at this practice or by this therapist. I encourage you to leave a voicemail if I am unavailable, and I will make every attempt to get in touch with you as soon as possible. But, for any number of unseen reasons, if you do not hear from me or I am unable to reach you, it remains your responsibility to take care of yourself until such time as we can talk. If you feel unable to keep yourself safe, go to your nearest emergency room and ask to speak to the psychiatrist or psychologist on call. You may also call the 24 hour crisis and suicide hotline for the Indianapolis area at: **1(800) 560-4038.**

**15) PLANNED ABSENCES**

I will make every attempt to inform you in advance of any planned absences, and provide you with a name and phone number of the therapist covering the practice. **I do not conduct therapy via email or text messages.** I do not respond to emails by providing therapy outside of sessions, unless we have mutually determined and agreed upon this as being beneficial to the process of your therapy.

**My email address is offered to clients as an additional method of reaching me to discuss scheduling issues only.** I will also accept text messages as a way of contacting me to discuss scheduling issues. Should you need to email me information pertaining to sessions or for therapy related concerns, please note that I will read any information sent to me and will only respond face- to-face during your scheduled session times with you present in the room. This ensures a safe and productive therapy relationship and minimizes the chances of miscommunication that can often occur with written correspondence.

**16) ONLINE COUNSELING**

The potential benefits of receiving mental health services online include both the circumstances in which the counselor considers online mental health services appropriate and the possible advantages of providing those services online. Once it is determined and agreed upon by both the therapist and the client that this is an appropriate option, clients will be provided with an invitation by Wecounsel.com, a HIPAA compliant online software. The client portal will be protected by meeting HIPAA compliance standards to ensure confidentiality of the online therapy services being offered. There are various risks related to electronic provision of counseling services related to the technology used, the distance between counselor and client, and issues related to timeliness. For example, the potential risks of message based counseling may include (1) messages not being received and (2) confidentiality being breached through unencrypted email, lack of password protection or leaving information on a public access computer in a library or internet café.

Your counselor has selected an account with Wecounsel.com for messaging and video communications to allow for the highest possible security and confidentiality of the content of your sessions, as it is HIPAA compliant. In order to benefit from these safeguards, the client is required to download, register and utilize the chat and video software from Wecounsel.com. Your personal information is encrypted and stored on a secure server in compliance with HIPAA regulations. The client is responsible for creating and using additional safeguards when the computer used to access services may be accessed by others, such as creating passwords to use the computer, keeping their email and chat IDs and passwords secret, and maintaining security of their wireless internet access points. Please discuss any additional concerns with your counselor early in your first session so as to develop strategies to limit risk.

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**SIGNED CONSENT**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELEASE OF INFORMATION**

It is in your best interest for you to give me permission to consult with your primary physician or psychiatrist. If I have your permission to consult with these professionals, please sign below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician/Psychiatrist or Other Party Name Telephone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your signature of authorization

Do I have your permission to call you and leave a voice mail message when needed for scheduling purposes?

(Please Initial) \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Yes No

What telephone numbers do I have permission to contact you and/or leave a message at?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Home Work/Other

Who should I contact in case of an emergency?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship to you Phone number

If this information changes at any time, please advise me as soon as possible and I will update the information in your file.

**CONSENT FOR THE TREATMENT OF MINORS**

“I/We consent that my son/daughter/child, under legal guardianship under the age of 18,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, may be treated as a client by Ashley Mangus MSW, LCSW”

**CONSENT TO THERAPY**

Your signature below indicates that you have read this Agreement and agree to its terms as consent to treatment. It also serves as an acknowledgment that you have received a copy of this agreement and have been provided a copy of the HIPAA Notice Form described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature/Date Client Signature/Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Name (Print) Client Name (Print)

Therapist Signature/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_