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INFORMATION, DISCLOSURE, & CONSENT TO TREATMENT

Welcome to my practice, Gina Campbell Counseling, LLC. I am very pleased that you selected me as your therapist and I am sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from me as your therapist. Although providing this document is part of an ethical obligation to my profession, more importantly, it is part of my commitment to you to keep you fully informed of every part of your therapeutic experience. The relationship with a therapist is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time.

COUNSELING & PSYCHOTHERAPY:
The words counseling and psychotherapy are often used interchangeably to indicate forms of help that address various kinds of personal and family distress such as depression, anxiety, adjustment difficulties at work or with other people, and marital and family conflicts. The goals of therapy range from the relief of symptoms to significant life changes based on acquiring a better understanding of one's personal, interpersonal and social circumstances.

I approach counseling from many perspectives, but what they all have in common is a focus on your strengths and resources. The goals of counseling vary from client to client and because of this the number of counseling sessions needed to achieve a client's goals varies. As a client, you are in complete control, and you may end your relationship with me at any point. Please keep in mind that appropriate closure of the counseling relationship in the form of a final face to face session can be helpful and honors the work we have done together.

In order for therapy to be most successful, it is important for you to take an active role. This means working on the things we talk about both during and between sessions. Generally, the more of yourself you are willing to invest, the greater the return.

Furthermore, it is my policy to only see clients who I believe have the capacity to resolve their own problems with my assistance. It is my intention to empower you in your growth process to the degree that you are capable of facing life's challenges in the future without me. I also don't believe in creating dependency or prolonging therapy if the therapeutic intervention does not seem to be helping. If this is the case, I will direct you to other resources that will be of assistance to you. Your personal development is my number one priority. I encourage you to let me know if you feel that transferring to another facility or another therapist is necessary at any time. My goal is to facilitate healing and growth, and I am very committed to helping you in whatever way seems to produce maximum benefit.

CONFIDENTIALITY & RECORDS:
Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be maintained in a secure computer database, which is password and fingerprint protected.

The laws and standards of my profession require that I keep PHI about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to me confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. I will always keep everything you say to me completely confidential, with the following exceptions:

(1) There are times when someone's life is in danger. For example, "suicidal and/or homicidal intent" means placing someone in danger (either yourself or someone else) and under those conditions, I am required by law to take necessary action to protect that person. Such action may include hospitalization, notification of the police, notifying an intended victim, etc.

(2) There are times when I discover, or strongly suspect, that a minor child, an elderly person or a person who is disabled is being abused, either physically or sexually. State law requires your therapist to report such information to the Department of Family and Children's Services in the county wherein the child resides. The law is designed to protect children from harm and the obligation to report actual or suspected abuse or neglect is clear.

(3) If you are involved in litigation of any kind and inform the court of the services you receive(ed) from us (thereby making your mental health an issue before the court) you may be waiving your right to keep your records confidential. Please consult with your lawyer and your therapist before doing so.

(4) If you direct your therapist to tell someone else your PHI and you sign a "Release of Information" form, I may release information you specify. As a result, I may request your permission to contact your primary care physician or psychiatrist to coordinate your care.

STRUCTURE AND COST OF SESSIONS:
My standard fee for psychotherapy services is $125 per 50 minute session, unless otherwise negotiated by you or your insurance carrier. The fee for each session will be due at the conclusion of the session. You may pay by cash, personal checks and credit card and I will provide you with a receipt of payment if needed. The receipt of payment may also be used as a statement for insurance if applicable to you. Please note that there is a $25 fee for any returned checks.

Insurance companies have many rules and requirements specific to certain plans. It is your responsibility to find out your insurance company's policies and to file for insurance reimbursement. I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

CANCELLATION POLICY:
If you need to cancel your scheduled appointment, 24 hours notice prior to your session time is required. I require this notice so that your appointment time can be filled by another client. Without prior notification, the time cannot be filled. For that reason, you will be charged the full fee for missed sessions that were not cancelled within 24 hours of the session. Please note that insurance companies do not reimburse for missed sessions.

IN CASE OF AN EMERGENCY:
Gina Campbell Counseling, LLC is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a pager nor am I available at all times. If at any time this does not feel like sufficient support, please let me know and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, I will return phone calls within 24-48 hours. If you have a mental health emergency, I encourage you not to wait for a call back, but to do one or more of the following:

Unity Point Behavioral and Mental Health (515) 263-5249
Mercy Behavioral Health (515) 271-6111
Broadlawns Medical Center Crisis Team (515) 282-5752

Call 911

Go to your nearest emergency room.

In addition, call my office at **(515) 512-4254** and leave me a message. Please know that I will attempt to return your call as soon as possible. If you call outside of regular work hours or over the weekend, your call may not be returned until the next working day.

GENERAL CONSENT TO THERAPY

By signing below, you are agreeing to the office policies that have been described above. Please initial and sign below:

__ I have seen and read the information contained in this Information, Disclosure and Consent Form.

__ I consent to treatment as described in this form.

__ I will pay for my therapy expenses as described above.

__ I authorize the release of healthcare information necessary to process insurance claims generated by Gina Campbell Counseling, LLC. I understand that I am responsible for any amount not covered by my insurance.

__ I hereby authorize payment directly to Gina Campbell Counseling, LLC for any benefits due me for counseling/ psychotherapy.

__ I understand that I am responsible for any amount not covered by my insurance.

__ I have read a copy of the Confidentiality/HIPAA Practices and understand that I may request a copy for my records.

__ I have read the cancellation policy and agree to pay fees for appointments cancelled with less than 24 hours notice.

Client Signature(s) _____ Date _____