**Professional Disclosure Statement and Informed Consent Example**

**Directions:** Utilize this example professional disclosure statement and informed consent to assist you with formulating your one-page informed consent assignment.

**Professional Disclosure Statement and Informed Consent**

Welcome and thank you for choosing me as your practitioner. This document is designed to let you know about my training background, what to expect from treatment, and my billing practices. This form is also required by law.

Who am I? My therapeutic approach is based in Cognitive Behavioral Therapy and trauma informed approaches. I am a firm believer in the mind-body connection and its effects on our wellbeing.

I am a licensed behavioral professional in the state of Arizona and completed my Masters studies in 2004. To verify this, you may visit the Arizona State Board of Behavioral Health Examiners website at <http://www.azbbhe.us/> and verify my licensure.

**The Therapeutic Relationship:** A therapeutic relationship is developed slowly between a counselor and a client. I will act as a guide in this relationship, but you will be the primary change agent. I believe that we all have the answers to the questions we ask, we just sometimes need an unbiased guide to help us find that information. It is crucial that we both pride each other with feedback regarding the therapeutic relationship on an ongoing basis. The time we spend together should be as effective as possible, your time is much too important to waste.

**Possible Benefits of Treatment:** Behavioral therapy can be highly beneficial to the individual. Most models are designed to help the client build skills and learn adaptive coping methods. Behavioral therapy can possibly cause temporary distress as well. What you talk to your professional counselor about is not always a great subject for you. It is normal for some clients to incur some distress during the treatment process. For trauma clients this is especially true and they may experience flashbacks, anxiety, intrusive memories and sleep problems. This is not an exhaustive list of probabilities everyone has their own response. I will do my best to help you learn coping mechanisms for those side effects and I ask that you also complete homework assignments in preparation.

In the case of overly disturbing symptomatology, you may call me for help. If it is after hours or on the weekend, you may call the crisis line on your insurance card or call Maricopa Crisis Response Network at 602-222-9444. During normal business hours, I can return calls within 6 hours. If you need an immediate response, please call the crisis line. In the advent that I am away from my office for an extended period, I will leave a peer professionals name on the voicemail message for clients to have access to help.

**Confidentiality:** It is my legal and ethical obligation to keep any information about you and your therapy confidential. There are certain limits to your right to confidentiality, which are explained in detail below. In addition, I contract with a medical billing company, Symbiotic Medical Billing, and must provide them with a minimum of information about you in order for them to perform their duties for me. Heritage Medical Billing also agrees to follow all applicable laws when handling your private health information. If you are using insurance to pay for therapy, I must likewise communicate with your insurance company regarding your treatment.

**Code of Ethics:** As a professional counselor, I am beholden to the American Counseling Association code of ethics to guide my practice. You may find that code online at <http://www.counseling.org/knowledge-center/ethics>.

**Fees:** The charge for therapy is $125.00 per clinical hour and is due at the time of services. I do accept credit cards, but no personal checks or PayPal. If you are using your insurance, you are responsible for the copay amount, which we will discuss at the time of intake.

**Consent to Treatment:** I authorize Bonnie Bell, to provide counseling services to me. I understand the potential risks and benefits of counseling, and I understand that I may ask questions about my treatment and request a review of my treatment progress at any time. I agree that my request for services is voluntary and that I may discontinue treatment at any time. I acknowledge that no guarantees have been made to me regarding the results of treatment provided. I understand my rights as described above. I agree to take financial responsibility for my sessions at the rate of $\_\_\_\_\_ per 50-minute session, or as required per my insurance policy, as described in the above section on Fees. I certify that I have read, had explained to me where necessary, fully understand, and agree with the contents of this Professional Disclosure Statement and Consent to Treatment.

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_