INFORMED CONSENT

Thank you for choosing Jen Wildhaber, LCPC ATR. 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. Treatment practices, philosophy, plan limitations and risks will also be discussed with you today. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

THERAPIST BACKGROUND:

Jen has earned a Master's Degree in Art Therapy Counseling from the Southern University of Edwardsville. She is licensed by the State of Illinois as a Licensed Clinical Professional Counselor and a Registered Art Therapist. She has over 15 years of clinical experience in treating children and adolescents ages 3-18, adults with disabilities, and their families using individual, and group therapy. Jen has worked in a variety of settings, including a private day school, women's shelter, and in private practice. Jen has extensive training and experience working with children, adolescents, adults and their families dealing with Autism Spectrum Disorders, Attention Deficit Hyperactivity Disorder and related disorders.

THERAPUETIC PROCESS: Jen practices Art Therapy and Cognitive Behavioral Therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Jen uses a combination of art therapy and cognitive behavioral therapy when working with clients. Both of these interventions may be used individually or as a dual process.

Art Therapy: Art Therapy is a mental health profession that uses the creative process of art making to improve and enhance the physical, mental and emotional well-being, of individuals of all ages. It is based on the belief that the creative process involved in artistic self-expression helps people to resolve conflicts and problems, develop interpersonal skills, manage behavior, reduce stress, increase self-esteem, self-awareness, and achieve insight.

Cognitive Behavioral Therapy: Cognitive Behavioral Therapy works by changing people's attitudes and their behavior by focusing on the thoughts, images, beliefs and attitudes that are held (a person's cognitive processes) and how these processes relate to the way a person behaves, as a way of dealing with emotional problems.

Client/Therapist roles: Counseling is a mutual collaborative process. You and Therapist will work together to develop goals on which you want to work. Your therapist cannot change you, but acts as a facilitator. Only you can change yourself. You are responsible for making an effort to work on the problems that concern you. Your therapist is committed to help you in the process. For therapy to be most effective it is absolutely essential that you take an active role in the process. Therapy works best when you and your counselor develop a good working relationship, based on mutual trust, honesty and respect. If you experience any problems or difficulties relating to your counselor, you are encouraged to discuss these with her and attempt to reach a solution. Sometimes you and your counselor may decide that it is best for you to meet with another therapist.

Risks of therapy:

- Client may experience uncomfortable feelings while creating art or during a cognitive behavioral activity.
- Therapy can be challenging, as you work through your goals, symptoms may become worse before they improve.

Benefits of therapy

- Therapy can release emotional pain, reduce symptoms, improve relationships, and change behavior or lifestyle.
- During therapy you may learn to pay attention to your thoughts and feelings. The therapist will guide and support you through this process.

TERMINATION: You have the right to terminate therapy at any time. It is important that you discuss the matter of termination with your therapist. Length of therapy will be determined by reaching maximum benefits and meeting goals set. Throughout therapy you and your therapist will discuss recommended course of treatment, goals and methods recommended for obtaining these therapy goals.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or your child or children report about physical, sexual abuse or elder abuse; then, by Illinois 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/ or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Jen will follow those emergency services with standard counseling and support to the client

or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.

CONSULTATION WITH COLLEAGUES: During the duration of therapy your therapist may consult with their colleagues pertaining to your case. When consulting with their colleagues no identifying information will be given at any time.

FINANCIAL/INSURANCE ISSUES: 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. 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. In the event that 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 Jen Wildhaber.
Lastly, if you need to cancel or reschedule an appointment, please give 24 hours advance notice; otherwise you will be billed $30.00. If you do not show or do not call to cancel a scheduled appointment you will be billed $60. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

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 the term of treatment. **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/PSYCHIATRIST NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

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.

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 _____?*

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ may be treated as a client by Jen Wildhaber. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

CO-ORDINATION WITH CHILD'S SCHOOL: Jen may wish to work in cooperation with faculty and staff at your/ your child's school and school district. As such, we ask your permission to communicate with these individuals to coordinate and expand care for you or your child. This communication will be from Jen to the school and from the school to Jen. **Your consent is valid for the term of treatment.** If you decline, no information will be shared. You may change your decision at any time.
__You may communicate with the school. __I/ we decline the sharing of information.

ATTENTION:_____
SCHOOL NAME_____
ADDRESS_____**PHONE**_____

Signature(s)_____***Date***_____

Therapist Signature_____***Date***_____

You may have a copy of this form if requested.