

Christine Reber, LMHC, CASAC  
Orchard Park Counseling  
(716) 508-7393

3959 N Buffalo Rd  
Orchard Park, NY 14127

595 Blossom Rd, Suite 315  
Rochester, NY 14610

## Client Informed Consent for Treatment

Welcome to Orchard Park Counseling! I look forward to our work together. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and let us know if you have any questions.

### **Information about Christine Reber, LMHC, CASAC:**

I have been a practicing therapist for over 15 years in a variety of clinical settings. I hold a Master of Science degree in School Counseling from the College of Brockport, as well as a Certificate of Advanced Study in Mental Health Counseling. I am currently a Licensed Mental Health Counselor through the State of New York (license #006188) and a New York State Credentialed Alcoholism and Substance Abuse Counselor (certificate #22184). If you have any additional questions or concerns about my education and/or experience, I would be more than happy to speak with you further.

### **Risks/Benefits of Therapy:**

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

### **Insurance:**

I choose not to participate on any insurance panels for several reasons, primarily to protect your confidentiality. I am, however, considered an out-of-network provider for most insurance plans. I can generate a statement that you will be able to submit directly to your insurance company for reimbursement. It is your responsibility to contact your insurance company prior to your first session to inquire about the out-of-network benefits specific to your plan.

### **Fees:**

My fee for a 50-minute individual, couples/marriage, or family counseling session is \$120. Accepted forms of payment are cash, check (made payable to Christine Reber), and all major credit cards. Payment is due at the time the services are rendered (and is generally collected at the end of each session). There is a \$25 fee for all returned checks. If you wish to discuss a written agreement that specifies an alternative payment procedure, please to so prior to the session.

Please initial here to indicate your agreement with the fees/payment: \_\_\_\_\_

**Cancellation Policy:**

When you schedule a session, that time is reserved solely for you. Therefore, 24-hour notice is required to cancel or reschedule appointments. You will be charged the full session fee of \$120 for any missed sessions or sessions cancelled with less than 24-hour notice. I find that this is the fairest way for us to respect each other's time.

Notice of cancellation may be received by phone (or voicemail), email, or text message.

Furthermore, excessive cancellations or requests for appointment time changes are disruptive to the therapeutic process, as well as the therapist's schedule. Should this become a concern, the therapist reserves the right to terminate treatment or assess a \$25.00 re-scheduling fee.

**Please initial here to indicate your agreement with the cancellation policy: \_\_\_\_\_**

**Confidentiality:**

Issues discussed in therapy are generally legally protected as both confidential and "privileged". However, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child, elderly person or a disabled person.
2. When I believe you are in danger of harming yourself or another person (If you report that you intend to physically injure someone else, the law requires me to inform that person as well as the legal authorities).
3. If I am ordered by a court to release information as part of a legal involvement.
4. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
5. When otherwise required by the law.

**Professional Consultation:**

I regularly participate in clinical, ethical, and legal consultation with appropriate professionals in order to provide the best possible care for my clients. During these consultations, I do not reveal any of my clients' personally identifying information. If this practice presents any concerns to you, please let me know so that we can discuss it further.

**Therapist Availability/Emergencies:**

You may leave a message for me at any time on my confidential voicemail at **(716) 508-7393**. Calls will be returned within one business day, during normal workdays (Monday through Friday). Please note, however, that telephone calls will be kept brief due to my belief that important issues are better addressed during regularly scheduled sessions. **If you are experiencing a medical or psychiatric emergency, please call Crisis Services at (716) 834-3131 (Buffalo), (585) 275-5151 (Rochester), call 911 or go to your nearest emergency room.**

**About the Therapy Process:**

It is my intention to provide services that will assist you in reaching your therapy goals. Based on the information you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process. Remember, therapy is a service that you purchase, and if you are not happy with the services received, it is your responsibility to make that known to your therapist to avoid any hindrances to your progress. I will also periodically provide feedback to you regarding your progress and will ask for your participation in the discussion. I am unable to predict the length of your therapy or guarantee a specific outcome or result due to varying severity of problems and individuality of each client.

### **Termination of Therapy:**

The length of your treatment and timing of the termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. We will discuss a plan for termination as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either party may elect to initiate a discussion of your treatment alternatives.

Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

### **Technology Statement:**

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect your boundaries, and ascertain that your relationship with your therapist remains therapeutic and professional. Therefore, we've developed the following policies:

- **Cell phones:** It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a problem, please feel free to discuss this with your therapist.
- **Text Messaging and Email:** Both text messaging and emailing are not secure means of communication and may compromise your confidentiality. However, we realize that many people prefer to text and/or email because it is a quick way to convey information. If you choose to utilize texting or email, please discuss this with your therapist.

**However, please know that it is our policy to utilize these means of communication strictly for brief topics such as appointment rescheduling. Please do not bring up any therapeutic content via text or email to prevent compromising your confidentiality.**

### **Social Media:**

#### **Friending**

Therapists are not permitted to accept "friend" requests from current or former clients on their personal social networking sites (Facebook, Twitter, LinkedIn, etc.). Adding clients as "friends" on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

#### **Liking/Following**

You are welcome to "like" or "follow" our social media feeds and read or share articles that we post; however, because social media sites are public spaces, anyone who can see our social media pages can see your post or comment. In addition, when you post, comment, or "like" a page, it will be published on your page as well. Our primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow our practice.

In order to maintain ethical boundaries, therapists are not permitted to follow you back. We believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as part of your treatment or to satisfy curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on the therapeutic relationship. If there are things from your online life that you wish to share with your therapist, please bring them into your therapy sessions where those things can be viewed and explored with your counselor,

#### **Use of Search Engines**

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Due to the fact that therapists are mandated reporters, extremely rare exceptions may be made during times of crisis. If a therapist has reason to suspect you are in danger and you have not been in touch with your therapist via usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare.

Your signature below indicates the following:

I understand that I have the right to decline or refuse treatment. I have read and fully understand the information and policies described in this plan. I have discussed any questions or concerns with Christine Reber, LMHC, CASAC, and she has addressed all questions/concerns regarding this agreement to my satisfaction. I agree to abide by the terms and conditions of this agreement and consent to treatment with Christine Reber, LMHC, CASAC.

If the client being treated is under the age of 18, a parent/guardian will also sign this form, and this will serve as a "consent to treat a minor" document.

---

Client Signature

Date

---

Parent/Guardian Signature (if client is under the age of 18)

Date

# Credit Card Authorization Form

You are **required** to complete this form even if you do not plan to pay for your sessions via credit card (a deposit check in the amount of \$120 may be left in lieu of credit card information). This form will be securely stored in your clinical file and updated upon request at any time.

By signing this agreement, I authorize Christine Reber, LMHC, CASAC to bill my credit card for professional services rendered to the "client" under the following circumstances:

1. Missed/forgotten payments (payment for sessions are due at the time the services are rendered).
2. Sessions that are not cancelled with at least 24-hour advanced notice (as outlined in the cancellation policy) will be charged the full session fee of \$120.
3. Returned checks will incur the check amount plus an additional \$25 bank fee.

Credit Card Type (check one):  Visa  MasterCard  Other

Number: \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Verification/Security Code (3-digit code on back of card by signature line): \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Please initial each of the following authorizing:

\_\_\_\_ Payment for any missed/forgotten session fees. Payment is due at the time services are rendered.

\_\_\_\_ \$120 cancellation fee for any session cancelled or missed without 24 hour advanced notice.

\_\_\_\_ Returned checks will incur the check amount plus an additional \$25 bank fee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Christine Reber, LMHC, CASAC, in writing, of any changes in my account information or termination of this authorization at least 2 days prior to the next billed session. I understand that the payments may be executed within a week of the session date. I acknowledge that the origination of transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card account and will not dispute these scheduled transactions with my bank or credit card company, so long as the transactions correspond to the terms indicated in this authorization form.