Healing Waters Counseling Center, LLC.

Director: Bradley T. Kinder, M.S., LPC, CSAC
Licensed Professional Counselor
Certified Substance Abuse Counselor

INFORMED CONSENT

Thank you for choosing Healing Waters Counseling Center, LLC. We realize that beginning outpatient mental health services is a major decision and that you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Bradley T. Kinder, M.S., LPC, CSAC serves as the founding owner and Clinical Director of Healing Waters Counseling Center. He is a Licensed Professional Counselor and Certified Substance Abuse Counselor through the Virginia Board of Counseling. He has several years of clinical experience in treating children, adolescents, adults and families using individual, group, and family therapy. Other mental health professionals with Healing Waters Counseling Center, LLC are independently licensed (i.e., Licensed Clinical Social Worker, Licensed Professional Counselor, or Licensed Psychiatrist) or are working under the license of a Licensed Clinical Supervisor. If applicable, this will also be discussed with you today. Cognitive Behavioral Therapy is used for most conditions, although other treatment approaches may be used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you.

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 you child or children report about physical, sexual abuse or elder abuse; then, by Virginia State Law, I am obligated to report this to the Virginia Department of Social 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 f) when required by law, or e) for the purpose of billing and/or collections. I understand that Healing Waters Counseling Center, LLC does not provide emergency services. However, I have been informed of whom to call in an emergency or during weekend and evening hours. I have also been informed of the regular office hours.*

Signature(s)_____Date:_____

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 or 50% of the fee. 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. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). 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 Healing Waters Counseling Center, LLC.*

I have received a copy of my fee schedule

Signature(s)_____Date_____

Lastly, if you need to cancel or reschedule an appointment, 24 business hours advance notice is required, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. ***You may have a copy of this form if requested.***

Signature(s)_____Date_____

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 one year.* ***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(s)

PHYSICIAN NAME:_____

CLINIC:_____

ADDRESS:_____

PHONE:_____

Signature(s)_____Date_____

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 ☐***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 Healing Waters Counseling Center, LLC. 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.*

Signature(s)_____Date_____