SEED OF HOPE COUNSELING SERVICES, PLLC

Gateway Executive Suites, 4140 E. Baseline Rd, Suite 101, Mesa, AZ 85206 ph: 480.455.0915 fx: 480.545.2260

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I look forward to working with you! Please read and sign the following informed consent form; we will also review this document during our first counseling session as well as answer any questions that you may have.

Professional Disclosure and Treatment Agreement: Dr. Jeffries earned a Master of Arts in Biblical Counseling from Dallas Theological Seminary and a Doctor of Behavioral Health degree from Arizona State University. I am licensed by the Arizona Board of Behavioral Health Examiners as an Independent Licensed Substance Abuse Counselor which has been my career since 2001. The primary focus of my private practice is substance abuse, DUI services, stress management, behavioral issues, anger management, coping/problem solving skills, and career assessment/counseling. Clients that present with custody issues or legal court issues will be referred to other providers or programs that specialize in these areas.

My treatment approach includes assessment/evaluation, 12 step program, cognitive behavioral (CBT), relapse prevention, family systems, motivational interviewing, brief psychological testing, drug education (for parents), and aftercare planning. Treatment modality includes individuals, groups, and family therapy. I will only accept clients that I believe are willing to embark upon the challenging journey of change, especially in the area of substance abuse. I reserve the right to refer a client to another therapist or appropriate resource at any time if their needs in therapy are not a good match for my skills or experience.

There will be times in our counseling sessions when we will discuss sensitive and emotional issues, it is important to remember that we have a professional relationship rather than a personal one. Please do not offer gifts or invite me to social events and in the event that our paths cross in a social or public setting; I will not initiate a greeting. I'm not trying to be rude; however, I am attempting to protect your privacy.

Confidentiality: All sessions are kept confidential. No information will be released without the client's consent unless mandated by law. I am required by law to disclose confidential information to the appropriate authorities when; (1) the therapist hears of or suspects child abuse, elder abuse, or dependent adult abuse, (2) the client is thought to be in danger of harming him/herself, (3) when the client threatens serious harm to someone else or, (4) when required by court order.

Purpose, limitations, and Risk of Treatment: Counseling/therapy like most endeavors in the helping profession is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually

involves working through personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended.

Counseling/therapy may result in decisions about changing behaviors, employment, substance abuse, education, housing, relationships or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling; I will refer you to a therapist that specializes in this area.

Treatment Process and Rights: Your treatment process will begin with one or more sessions devoted to an initial intake and/or psychological assessment so that I can get a good understanding of the issues, your background and any other factors that may be relevant. When the initial intake and or assessment process is complete, we will discuss ways to treat the problem (s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal.

Consent for Co-Joint Treatment: I ______________________________, understand that if at any point in my treatment, I participate in a co-joint treatment session, (someone other than you and your counselor in the therapy room) with you while treatment is in progress, that my confidential information will be shared as part of that session process. I am aware and I agree that when I invite someone to join me in session, that my confidentiality will be limited dependent on the session process. I agree that I will not hold the counselor liable for any information shared during that session.

____
CLIENT PRINTED NAME

____ _____________________
CLIENT SIGNATURE DATE

Sessions: There are sometimes misunderstandings about the length of sessions. Therapy sessions, as defined by the American Medical Association Current Procedural Terminology coding, are 45-50 minutes, not one hour. This is known as a "therapeutic hour." Please let me know in advance if you would like to schedule a longer appointment. If you are late for an appointment, your session will still end at the normal time. My policy requires a 24-hour cancellation notice. Please refrain from drinking alcohol or using drugs that would cause you to be intoxicated at the time of your session. If the therapist suspects the client is under the influence of drugs or alcohol, the session will be terminated and if the client is currently on

probation; his/her probation officer will be notified immediately.

Fees and Payment: I currently accept Cash, Checks, and Credit Cards.

Initial Assessment:	$110.00	(1 1/2 Hr)
Individual Session:	$95.00	(1 Hr)
Family Session:	$125.00	(1 Hr)

The fee for each session will be due and payable at the time of service

Telephone Contact: If you need to contact me between sessions, please leave a message on my voicemail at 480-455-0915 and your call will be returned as soon as possible. I do check messages several times during my workday, unless I am out of town or with a client. If an urgent situation arises, please contact the community emergency services (911).

Notice of Privacy Practice (HIPAA)

Signing this document means I have read the NPP and have been made aware of how my medical records may be used and disclosed.

PATIENT SIGNATURE DATE

PATIENT SIGNATURE DATE

THERAPIST SIGNATURE DATE