

INFORMED CONSENT

Thank you for choosing Norman C. Dasenbrook, MS, LCPC. 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. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Norman C. Dasenbrook, MS, LCPC has earned a Bachelor of Science Degree in Psychology and a Masters Degree in counseling and Guidance from the University of Wisconsin Whitewater. He is licensed by the State of Illinois as Licensed Clinical Professional Counselor. He has over 25 years of clinical experience in treating adolescents, adults and families using individual and family therapy. Norm practices standard cognitive-behavior therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan as well as limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) 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. Norman C. Dasenbrook will follow those emergency services with standard counseling and support to the client or the client's family.

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 the Counseling Center. I have received a copy of my fee schedule.

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, 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 TREATMENT: 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. If you prefer to decline consent no inform 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 (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 _____ maybe treated as a client. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s) _____ *Date* _____