



MEA CARES COUNSELING--INFORMED CONSENT

This consent form explains some important information about your counseling experience. Your counselor will review this information with you during your first counseling session. You will be asked to acknowledge that you understand the center's policies and your treatment.

POTENTIAL DUTY TO WARN--MEA Cares is committed to protecting the confidentiality and privileged communication of our clients. There are, however, exceptions to our ability to protect confidential information provided to us. For example, under Mississippi law, healthcare professionals are required to report reasonable suspicions of abuse and/or neglect of children and vulnerable adults. Also, when a client discloses intentions or a plan to harm another person or persons, the healthcare professional may be required to warn the intended victim and/or report this information to appropriate legal authorities. If a client discloses or implies a plan for suicide, the healthcare professional may be required to notify appropriate persons for the protection of the client's safety.

Client, please initial as a Potential Duty to Warn acknowledgement.

Counseling Services

- All of our counselors are licensed professionals with a minimum of a Master's Degree in social work, counseling, or psychology. All are experienced in a broad range of counseling issues and have specialized training in assessment and treatment.
- The Counseling Staff is available at our primary office located at 308 Corporate Drive, Ridgeland, MS and 7 Lakeland Circle, Jackson, MS. Office hours are 8:00 a.m. until 5:00 p.m. Monday through Friday. A counselor may be available after hours in the case of an emergency. An emergency is defined as being suicidal, homicidal, or actively psychotic.
- Our counseling sessions last approximately 50 minutes beginning at the scheduled start time.
- It is understood that a twenty-four (24) hour (minimum) notification to your therapist is an expected courtesy if you wish to cancel an appointment that was reserved for you. Appointments not canceled within twenty four hours prior to the appointment may be counted as one of your allotted sessions.
- If you are more than 15 minutes late for your appointment it may be considered a missed appointment and may also be counted as one of your allotted sessions.

CONSENT FOR TREATMENT

Authorization for treatment, release of medical information, assignment of insurance benefits, and fees.

Authorization to Release

I hereby authorize MEA Cares and any physician providing treatment to me, to release or disclose to insurance companies and/or outpatient benefit programs and their designees all information from my medical record pertaining to my medical treatment as needed to process insurance claims.

Authorization to Pay Insurance Benefits

I hereby assign payment directly to MEA Cares of all insurance and similar benefits otherwise payable to me by virtue of mental health medical treatment provided by MEA Cares, but not to exceed MEA Cares' regular charges for mental health medical treatment. I understand I am financially responsible for charges not covered by insurance, and I hereby agree to be responsible for all charges incurred, regardless of the status of medical insurances or similar benefits.

Consent for Treatment

I, or the undersigned patient for whom I am legally responsible, am suffering from a condition requiring diagnosis and/or treatment. I voluntarily consent to such procedures and treatment. I am aware that the practice of psychotherapy is not an exact science, and I acknowledge that no guarantees have been made to me as a result of said therapy which I hereby authorize.

Payment Terms; Late Fee

I understand that payment in full is due on the date of treatment for all services provided, and I agree to pay all charges for the patient named below. If payment in full is delayed for any reason (such as the failure of my insurance to pay the balance in full), I agree to pay the full balance.

Additional Fees

There may be additional fees if you, or someone representing you, make a request for Written Reports that include but are not limited to File Summaries, Note Production, Release of Information, Preparation of Forms, Recommendations as a result of Counseling, and Verification of Attendance.

I understand that due to the nature of the therapeutic process, it often involves making a full disclosure of many confidential and intimate matters. Therefore, it is agreed that should there be legal proceedings, neither you, or your attorney, or anyone else acting on your behalf will call our counselors to testify in court or at any proceedings, nor will a disclosure of the psychotherapy records be requested. However, if we should receive a subpoena by the Court, you will be responsible for the individual hourly court fee which is applied for all professional time allocated for our services (e.g. travel time, paperwork time, etc.).

In addition to any other applicable fees (e.g. postage), the following fees may apply:

- 1. Written Reports: \$130.00 per hour
- 2. Copies: \$20.00 for pages 1-20. \$1.00 per page for the next 80 pages, and 10% of total may be added for postage.
- 3. Court Preparation/Testimony: \$250.00 per hour

Valuables

The undersigned hereby releases MEA Cares and/or its staff of employees from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons while on the premises of MEA Cares.

My signature affirms that I voluntarily agree to participate in the assessment and counseling that is offered by MEA Cares Counseling. I further affirm that I have read or heard the information above and that it was presented to me in a clear, non-technical language. This information is understood by me and enables me to make an informed voluntary consent to this counseling process

Printed Patient Name

Signature Patient/Guardian (if patient under 15)

Date