INFORMED CONSENT

Thank you for choosing **Partners for Healing and Changework.** *Today's appointment will take approximately 75-90 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. Michael J. Adornetto has earned a Masters Degree in Social Work from the University of Pittsburgh in Pittsburgh, Pennsylvania. He is licensed by the State of New Jersey as a Licensed Clinical Social Worker. He has over 15 years of clinical experience in treating adolescents, adults and families using individual and family therapy. Michael practices standard cognitive-behavior and family systems therapies for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan 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 , 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 New Jersey State Law, I am obligated to report this to the Division of Youth 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. Partners for Healing and Changework 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, when requested, we will provide you with a computer generated statement that you may submit to your insurance company.* **Partners for Healing and Changework** *does not bill insurance companies directly. Payment by cash or check is expected at the time of service. 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.*

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 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. If you prefer to decline consent no inform will be shared.*

____**You may inform my physician(s)** ____**I decline to inform my Physician**

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

Signature(s)_____***Date***_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that _____ may be treated as a client at Partners for Healing and Changework. 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***_____