CONSENT FORM FOR THERAPY
BNM Safezone therapy

Welcome to the therapeutic practice of **BNM Safezone**. This document contains important information about our professional services and business policies. It also contains information about our policies and practices to protect the privacy of your health information. Please read this document carefully and let me know if you have any questions or concerns. By signing this document, you will be stating that you were provided with this information and it will represent a binding agreement between us.

Psychotherapy Services: Psychotherapy varies depending on the therapist, the client and the client's particular situation and goals. There are many different methods which may be used to deal with a particular situation, goals, and objectives. For the best outcome, each client must choose to invest energy in the process and work actively on relevant topics both during and between sessions. Psychotherapy can have benefits and risks. The risks may include experiencing uncomfortable feelings like sadness, guilt, anger, anxiety or frustration when discussing aspects of life. Psychotherapy has been shown to have benefits that can include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in feelings of distress. However, there are no guarantees as to what each client will experience.

What to Expect: The first few sessions will involve an evaluation of your situation including needs, goals, and objectives to work toward. Psychotherapy can involve a significant investment of time, energy, and money. It is important to select a therapist with whom you are comfortable working. If at any time you have questions about therapy, please discuss them with me as they arise.

Sessions: We schedule 1 hour sessions. If you would like longer sessions, the price will be pro-rated according to the length of appointment we agree upon. If you arrive late for an appointment, the remaining time of our scheduled session is available to you if you have called to state you will be late. If you have not called, we may not be available after 15 minutes from the scheduled start time. At times, it may be appropriate to meet more or less than once per week if that is consistent with the agreed upon treatment plan.

If you need to cancel a scheduled therapy session, you must do so at least 24-hours in advance.

Professional Fees: Fees are listed on the Counseling Fees document. Package rates are available which can be found on our website (www.goodnewsmentalspace.com). In addition to regular sessions, it is policy to charge the therapy rate on a pro-rated basis for other professional services required. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals which have been authorized, preparation of records or treatment summaries, and time spent performing any other professional service.

Billing and Payments: You will be expected to pay the full agreed upon fee before the time of each session unless other arrangements have been made. Payments may be made by cash,mobile money or bank transfers. Payment schedules for other professional services will be agreed upon when/if they are requested.

Social Media Policy: We do not interact or accept "friend" requests via social media sites (Facebook, LinkedIn, etc) because it has the potential to compromise privacy and complicate our therapeutic relationship.

Confidentiality: In general, the law protects the privacy of all communication between a client and a mental health provider. We may only release information about your treatment to others if you sign a written authorization form. You may revoke any such authorizations at any time, which must be in writing. However, in the following situations, your authorization is not required to release your personal information:

- Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
- Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
- Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine or their derivatives, THC, and excesses

. • Therapist's duty to report the misconduct of mental health or health care professionals.

- Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
- Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
- Therapist's duty to release records if subpoenaed by the courts. • Therapist's obligations to contracts

(e.g. to employer of client, to an insurance carrier or health plan.)

Please discuss any questions or concerns you have about confidentiality with me at any time. If you have specific legal questions about the laws regarding confidentiality, the exceptions, and how it may relate to your situation, please seek formal legal advice from an attorney.

Other Client Rights: You agree that you understand the following:

- I have the right to request and receive confidential communication of my protected health information by alternate means or at alternative locations. For example, clients may request the therapist send any correspondences to an address other than the clients' home address if not wanting family members to know about therapy.
- I have the right to request that the therapist change information in my record. I understand I am required to make such requests in writing along with reasons for the requested changes. The client's request will be noted.
- I understand I generally have the right to receive an accounting of any disclosures the therapist has made of protected health information, which did not require client authorization.
- I understand my therapist may use or disclose my health information for treatment purposes including presentation of my case in consultation with other professionals or consultants who are bound by the legal framework of privacy and confidentiality for professional development and guidance purposes.

Changes in Services or Fees: we reserve the right to change the policies, practices, procedures and fees described in this document. You will be notified within 30 days of any such changes.

Safety: We strive to provide a safe environment for all. Please let me know immediately if you have concerns for your safety while at our office. You agree that if you engage in verbal, written or physical behavior that is threatening to a therapist or a therapist's family, or any other person, any therapist at may identify you to the police, explain that you are a client, and report the threatening behavior using your personally identifying information. Further, if needed, you agree that any therapist or other at S may take other legal action to ensure safety for any therapist and any therapist's family or other people at Good News Mental Space using your personally identifying information.

I understand the basic goals, ideas, and methods of this therapy. I have no important questions or concerns that the therapist has not discussed with me. I understand that reaching the agreed upon therapy goal is not guaranteed. I understand that therapy is successful for some people, moderately successful for others, and for some not successful at all. I further understand that the initial symptoms or problems that were presented to the therapist may initially become more intense.
I am agreeing to participate in the following types of services, while acknowledging that the course of therapy may change, and the participants may change, by agreement of all parties.
_____ Individual Therapy ……

Conclusion and Signatures: By signing below I am indicating I have received and read the information in this document, have discussed the contents with my therapist to my satisfaction, and agree to abide by its terms during the course of therapy. I understand I may request a copy of this document.

Client Name…….
ID Number…….
Phone Number…….

Physical Address …….
Signature…… .. Date
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Therapist Name…….
Signature……..
Date ……