Dr. Lindsay Martin
Licensed Professional Counselor

Lindsay Martin, PhD, LPC, NCC

Licensed Professional Counselor

lindsay@drlindsaymartin.com www.drlindsaymartin.com

Informed Consent For Counseling Services

As with any treatment, psychotherapy can have both benefits and risks. I understand that psychotherapy is a collaborative effort between therapist and client/family, and although treatment is expected to be helpful, therapists are unable to make guarantees that clients/families will feel better or that problems will be resolved. Maximum treatment benefits occur through regular therapy attendance; however, it may be possible to see a temporary worsening of symptoms while in treatment.

Since both evaluations and treatment sessions may involve discussing unpleasant or upsetting aspects of life, individuals may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness, among others. Such discussions may be an essential part of treatment and are undertaken to support the process of problem solving and working toward treatment goals. Often, unpleasant or distressing feelings decrease as therapy progresses. Potential benefits of therapy include improved relationships, solutions to specific problems, and reductions in feelings of distress, but there are no guarantees as to what you will experience.

A federal law, the Health Insurance Portability and Accountability Act (HIPAA), provides privacy protections and client/patient rights regarding the use and disclosure of your Protected Health Information (PHI). HIPAA requires that clients/patients are provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. It also requires that a signature is obtained to acknowledge the receipt of this information.
I understand that information shared during the course of counseling services is kept confidential except in circumstances governed by law.

Such exceptions include: (1) any threats to harm self or others; (2) any reports of child or elder abuse; (3) court order to disclose information; and (4) signed consent through the appropriate Release of Information by client and/or parent(s)/guardian(s) of minor clients.
I understand that if I will be utilizing applicable health insurance benefits, my insurance company may require some information regarding treatment in order to authorize or reimburse for services.

I understand that treatment sessions are typically 45-60 minutes in length. The first one or two sessions with clients generally involve an evaluation of needs. This initial evaluation period includes a clinical interview, as

well as self-report questionnaires by clients, when appropriate. The purpose of the evaluation is to establish a diagnosis (if any) and to make treatment recommendations.

I am aware that following the evaluation, clients may in some cases be referred to other professionals who are better suited to meet specific client needs. I understand that if therapy appears appropriate based on the initial evaluation, a possible treatment plan will be outlined, and a decision may be made as to whether I would like to work with Dr. Lindsay Martin or if I would like to receive referrals to other treatment providers.

I am aware that requesting a forensic report or testimony as to the content of treatment greatly jeopardizes the course of treatment, as well as the therapeutic relationship. Therefore, I knowingly and freely waive my right to request the release of such information (other than dates of sessions, length of sessions, attendance at sessions, and fee information) to my attorney or any other Officer of the Court. I understand that release of clinically significant information to any Officer of the Court shall be by Court Order, signed by a duly appointed Judge, only.

Acknowledgement of Informed Consent

Your signature on this document will represent an agreement with me. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

I, after reading the above, agree to permit Lindsay Martin, Ph.D., to provide me or my minor child/children with counseling services including evaluations, diagnosis, and/or other aspects of treatment or treatment planning. I agree to participate, to the best of my ability, in client care and treatment. Further, I understand that I have the right to voice any concerns regarding the counseling services that I receive. I understand that I may request a second opinion. I also understand that should I decide to terminate therapy or other counseling services, or change clinicians, I have the right to do so at any time.

I have read this document and agree to abide by it. I recognize that psychotherapy frequently brings up issues that are difficult to discuss and which may cause me discomfort to explore. My signature below indicates that I have read and understand all of the preceding information. I understand that I may ask my provider questions at any time about any of this, should the need arise.

I hereby acknowledge and accept the terms outlined above:

Print name here: _____

_____ _____

Client Signature Date

For Minors or those requiring Guardianship

On behalf of _____, my minor child or person entrusted to me for guardianship, I agree to the above policies and give permission for Lindsay Martin, Ph.D. to provide treatment.

Print name here: _____

_____ _____
Parent/Guardian Signature Date

Print name here: _____

_
_____ _____
Parent/Guardian Signature Date