

INFORMED CONSENT

Thank you for choosing Ivette M Gomez as your counselor. Today's initial appointment will take approximately 90 minutes; future appointments will average 50 minutes. I realize that starting counseling is a major decision and you may have many questions, please, feel free to ask me. This document is intended to inform you of the policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try the best to give you all the information needed. Ivette M Gomez has earned a Master's in Arts from New York University and a Master's Degree in Counseling Education from the University of Puerto Rico and is a Licensed Mental Health Counselor. Ivette's practice is holistic, incorporating body, mind and spirit and combines different approaches to counseling like the arts, cognitive-behavioral methods, trauma reduction, energy psychology techniques and Ericksonian Hypnosis. Some of these methods may be used with permission of the client, depending on the person and the situation presented. Treatment practices, time needed for certain processes, philosophy and risks will be discussed as needed.

Confidentiality and Emergency Situations:

Your verbal communication and clinical records are strictly confidential except for:

Reporting child abuse, elder abuse or abuse of a disabled person

Protecting against danger to self or others (duty to warn)

If an emergency situation for which the client feels immediate attention is necessary, the client understands that they are to contact the emergency services in the community. I will follow those emergency services with standard counseling and support to the client.

When you sign a release of information to have specific information shared.

Signature: _____ Date: _____

Financial Issues: All payments are due at the time of services rendered. We request you pay the balance due at the time.

I have received a copy of the fee schedule

Signature: _____

Lastly, if you need to cancel or reschedule an appointment, please, give 24 hour 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 fees, balances or payments, feel free to ask.

Signature: _____ Date: _____

Optional

Coordination of treatment:

It is important that all health care providers work together. As such, we would like permission to communicate with your primary care physician and or psychiatrist if this is needed. Your consent is valid for one year. Please, understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent, no inform will be shared.

_____ You may inform my physician ____ I decline to inform my physician

Physician name: _____

Clinic: _____

Address: _____

Phone: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

I have read the notice of practices and received a copy of client's rights

Signature: _____ Date: _____

Emergency Contact: _____ Tel. _____