Client Information & Acknowledgement of Informed Consent to Treat

Counselor/Therapist: Cherie Warriner, LCSW is a licensed clinical social worker, engaged in the practice of providing counseling services through St.Vincent Medical Group Center for Healthy Aging.

Definitions: Cherie Warriner, LCSW and St. Vincent Medical Group Center for Healthy Aging are hereinafter referred to as "the Provider".

Nature and Purpose of Services: The purpose of participating in counseling services is to help you better understand your situation, change your behavior or move toward resolving your difficulties. Using the Provider's knowledge of human development and behavior, the Provider will make observations about situations as well as suggestions for new ways to approach them. It is important for you to examine your feelings, thought, and behavior, and to try new approaches in order for change to occur.

The services the Provider offers can have benefits and risks. Since treatment often involves discussing difficult aspects of your situation, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. Additionally, counseling services have been shown to have benefits. Treatment may often lead to decreased symptoms of depression and/or anxiety, more meaningful relationships, solutions to specific problems and increased ability to utilize positive coping skills during stressful situations. However, there are no guarantees of what you will experience.

Extent and Timeframe of Services/Appointments: Appointments are made by calling 317-338-7780. Appointments are typically 45-50 minutes in length, but may vary. Generally the course of treatment is 4-6 treatment sessions, however adjustments will be made based on your specific set of circumstances.

Fees: The standard fee is $85.00 per session, however certain managed care insurance company contracts may have pre-set fees. If Provider is not credentialed with your insurance provider or your health insurance policy does not provide coverage for Provider's services or denies coverage, then you are responsible for payment of fees.

Missed Appointments: There may be unavoidable circumstances that necessitate cancelling or missing a scheduled appointment. We ask that you kindly give as much notice as possible; preferably 24-hours. Call 317-338-7780 or 317-338-7520 to provide such notice.

Relationship: You and the Provider will have a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the Provider not have any other type of relationship with you. Personal and/or business relationships undermine our professional and therapeutic relationship.

Goals: There may be alternative ways to treat the problems you are experiencing. It is important for you and the Provider to discuss any questions you may have regarding your treatment and for you to have input into setting the goals for your therapy. As your therapy progresses, these goals may change. The Provider will work with you to address the changes in your goals.

Professional Records and Privacy: Your privacy is of upmost importance to the Provider and is key to the therapeutic relationship. The Provider is legally required to keep documentation about the services provided to you in your Clinical Record. Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways the presenting problem affects your life, your diagnosis, your treatment goals, your

progress toward those goals, your medical, social and treatment history, results of clinical tests, any past treatment records that the provider receives from others, reports of any professional consultations, copies of any reports the Provider has sent to anyone and either annotations or copies of emails we exchange, if applicable.

The Provider may also keep therapy notes which are for the Provider's own use and designed to assist the provider in providing you treatment. These notes are kept separate from your Clinical Record. They are not considered part of your Clinical Record and are not released, except in rare legal circumstances.

There are certain instances in which disclosure is necessary to prevent serious, foreseeable, and imminent harm to a patient or other identifiable person. Provider is considered a mandated reporter and is required report in the following circumstances:

- Provider has reason to believe a child is a victim of child abuse, neglect or exploitation.
- Provider has reason to believe an endangered adult is a victim of abuse, neglect or exploitation.
- If a patient communicates an actual threat of violence or other means of harm against an identifiable victim or indicates that there is an imminent danger that the patient will use physical violence or other means to cause serious personal injury or death to others, the Provider has a duty and is legally compelled to warn the intended victim and/or notify the appropriate law enforcement agency..
- Provider assesses that a patient is potentially harmful to themselves or others.

After-Hours Emergencies: In the event of an emergency, go to a hospital Emergency Room or call 911. If you are experiencing distressing symptoms, having thoughts of harming yourself or others call the **St. Vincent Crisis Line at 317-338-4800 or 800-872-2210**

Consent: By my signature below:

- I hereby give my informed consent to receive mental health counseling services from the Provider;
- I understand that I have the right to refuse or withdraw the informed consent given above;
- I understand and agree that I will participate in the planning of my care, treatment, and services and that I may stop such care, treatment and services at any time;
- I understand that there are no guarantees that treatment will be successful;
- I agree that, in the event of disability, death, or resignation of the Provider, I will instruct the provider where to send my records;
- I acknowledge that I have read (or have had read to me) and understood the above information contained herein and that I have been given an opportunity to ask questions concerning this document; and I acknowledge that I have been given a signed copy of this document.

Signature of Patient/Legal Representative:_____

Date:_____ **Time:** _____

Relationship to Patient: _____

Signature/Title of Witness to Patient Signature: _____