Crystal F. Crawford, MS, LPC
215 Walnut Street, Suite 1
Gadsden, AL 35906
256.459.4829
crystal@findingfortitude.com

INFORMED CONSENT

Thank you for choosing **FINDING FORTITUDE COUNSELING, LLC**. Today's appointment will take approximately 60-90 minutes in session. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. I, Crystal F. Crawford, MS, LPC, have earned a Bachelor of Science Degree in Psychology and a Masters Degree in Counselor Education with a concentration in Community Agency Counseling from Jacksonville State University. I am licensed by the State of Alabama as a Licensed Professional Counselor. I have 11 years of clinical experience in treating adolescents, adults, geriatrics, veterans, and families using individual and family therapy, with primary focus in marriage/couples counseling along with, individual counseling. I practice, faith-based counseling with standard person-centered and cognitive-behavior therapies for most conditions. Although, other appropriate treatment approaches are integrated depending on the person/s or condition/s. Treatment practices, philosophy, treatment 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 you and/or your child or children report about physical, sexual abuse, or elder abuse; then, by Alabama State Law, I am obligated to report this to the Department of Children and Family Services, **b)** where you sign a release of information to have specific information shared and **c)** if you provide information that informs me that you are in danger of harming yourself or others **d)** information necessary for case supervision or consultation and **e)** or when required by law. If an emergency situation for which the client or their guardian feels immediate counseling attention is necessary, please call the office to reach me, Crystal Crawford. If no call is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community **(911)** for those services. The client or guardian has the obvious option to call the emergency services **(911)** first, if preferred. I, Crystal Crawford, will follow up after the emergency services with standard counseling and support to the client or the client's family as needed. E-mail, text messages, and social networking sites are not confidential and I may not be able to respond.

Signature(s)____ Date:________

FINANCIAL/INSURANCE ISSUES: Finding Fortitude Counseling is a **private-pay** or **fee-for-service** based counseling practice, meaning that Finding Fortitude Counseling does **NOT** bill/file insurance companies, HMOs, responsible party, or third party payers at this time. It is requested that you pay the balance due at that time of service. If your balance exceeds $200.00, it will be asked that you pay for services when rendered. 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 my

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collection agency, the client or responsible party will be held responsible for any collection fee charged to my office to collect the debt owed. I ask that every client authorize payment of medical benefits directly to Finding Fortitude Counseling.

I understand & have signed a copy of my session fee & costs _______________ (initial).

You may put a credit card on file to pay for charges per session, if you prefer.

Lastly, if you need to cancel or reschedule an appointment, please give **24 business hours advance notice**, otherwise you will be billed up to the hourly rate. I sincerely appreciate your cooperation and at any time you have any questions regarding 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, I would like your permission, **if and when necessary** to communicate with your primary care physician and/or psychiatrist, **as necessary** in some cases. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization at this time, or 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 information will be shared. Please note, authorized information will not be shared before your knowledge and understanding as to why it would be necessary to do so.

____You may inform my physician(s) **____I decline to inform my physician**

PHYSICIAN NAME:____
CLINIC:____
ADDRESS:____
PHONE:____

Signature(s)____ Date______________

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s)____ Date_______________

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May we contact you at home? (circle one) **YES or NO.** May we contact you at work **yes no?** May we contact you by CELL phone? (circle one) **YES or NO** May we contact you by TEXT **YES or NO?** Where may we contact you________________________________?

If applicable enter name (s):

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____________________________________ may be treated as a client by Finding Fortitude Counseling. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Signature: ____ Date__________