



INFORMED CONSENT

Welcome to Natural State Counseling Centers Counseling

We are pleased you have chosen Natural State Counseling Centers Counseling for your counseling needs. Our team of counselors is highly trained across a range of disciplines. Our aim is to listen to our clients and help them accomplish their goals while respecting their values. We have access to many resources that you can use at your discretion, including, but not limited to, relational work, emotional processing, coping strategies, spiritual exploration, and psychological education. We are Master's-level Licensed Professional Counselors and/or Marriage & Family Therapists, or Licensed Clinical Social Workers. We are not authorized to give medical advice or to administer prescriptions. In an emergency when your therapist is unavailable, please go to your nearest emergency room or call Springwoods Behavioral Health or the Northwest Medical Center Behavioral Health Unit. It is important that you know that your therapist cannot guarantee a certain outcome in therapy, and in the event that a therapist is not equipped to meet your need, we will provide a referral. Providing you with the best care is our top priority.

Please review and complete this packet before your first appointment, then return it to us. We honor the effort and vulnerability it takes to entrust us with your care, and we look forward to the privilege of serving you.

_____ **Our relationship:** We are by law and ethics required not to have a dual relationship with any of our clients. Therefore, our contact will be limited to the paid sessions you have with us in our office. If we happen to encounter you socially, it is your option to acknowledge or not acknowledge us. This is an ethical requirement, which protects your confidentiality.

_____ **Confidentiality and Privileged Communication:** As an LPC or MFT, we are bound by Arkansas law (Act 593 or 1979 and Act 244 or 1997) to maintain your privileged communication as that of Attorney-Client. We will keep confidential the identity of our clients and anything a client shares with us with the following exceptions: 1) The client (custodial parent or guardian) directs us to give information to another, verbally and/or in writing, and releases us to disclose specific information for a specific purpose; 2) There is a threat of life by homicide or suicide or a clear and imminent danger to human life whereby we are mandated reporters; 3) we have a strong suspicion of abuse to children, the elderly or the handicapped; we are by law mandated reporters (Act 1208); or if court ordered.

In this clinic professionals do consult with each other regarding cases in order to better serve the client.

Your signature on this document gives your therapist permission to do this.

Each therapist maintains counseling information beneficial to your treatment. This information typically includes symptoms, medications, progress, test results, diagnoses and a summary of our services. This will continue during the course of your treatment with us.

In accordance with the ACA ethical code, your therapist will keep your records for a period of seven years. In maintaining the chart, the clinician is the owner of the chart but you are the owner of the information. You must sign an Authorization to Release form allowing your therapist to share any information with someone other than yourself. If the client is a child, the custodial parent has the right and the non-custodial parent may have a right to review the records. These are considered medical records. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it. In the event of the clinician's death, your records will be in a guardianship status with another appointed Mental Health Professional. Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the records and /or testimony by your therapist. We will not release records to any outside party unless we are authorized to do so by all adult family members who were part of the treatment. If you request a copy of the records, please be aware that there is a charge per document. We must advise you that records read by anyone other than the author are easily misinterpreted. A written summary is more appropriate and less likely to be misread.

_____ **Court testimony and subpoena policy:** Please be aware that for all court appearances as a witness, there is a charge for travel to and from the courtroom, consultation with your attorney and the actual court testimony. You have hired us to provide mental health psychotherapy. We are experts in relationships and gladly testify regarding our observations. However, we do not provide recommendations for custody or placement of children.

_____ **Electronic communication:** We are committed to your privacy and strict confidentiality. We utilize a service called Therapy Notes to keep our records. Each of our therapists has a confidential email, which can be encrypted through Hushmail. Cell phones, email, and fax should be used with caution, as we cannot guarantee your confidentiality. Notify us at any time if you would like to limit the use of these items.

_____ **Audio and Visual Recording of Therapy Sessions:**

To protect client privacy, confidentiality, and the therapeutic relationship, clients, parents, guardians, family members, or any other persons involved in services are not permitted to audio record, video record, photograph, livestream, or otherwise capture any part of a therapy session without the therapist's and practice owner's prior written consent. This includes in-person sessions, telehealth sessions, phone calls, consultations, parent sessions, family sessions, marital sessions, and any other clinical contact.

Recording a therapy session without written permission may violate the privacy rights of the client, therapist, and others involved in treatment. Unauthorized recordings may also interfere with the safety, trust, and openness necessary for effective counseling. If a recording is clinically appropriate, legally necessary, or requested for a specific purpose, this must be discussed with the therapist in advance and approved in writing by Natural State Counseling Centers.

By signing this informed consent, I understand and agree that I will not record any therapy session or clinical interaction without prior written permission from the therapist.

_____ **Use of Artificial Intelligence to Assist with Note Taking and Documentation:**

Natural State Counseling Centers may use secure technology tools, including artificial intelligence-assisted documentation tools, to support clinical note taking, treatment documentation, administrative efficiency, and continuity of care. These tools may assist the therapist in organizing clinical information, summarizing session content, drafting progress notes, or improving the accuracy and timeliness of documentation.

Artificial intelligence tools do not replace the therapist's clinical judgment, decision-making, diagnosis, treatment planning, or responsibility for the counseling record. The therapist remains responsible for reviewing, editing, and approving all clinical documentation before it becomes part of the client's record.

Natural State Counseling Centers will make reasonable efforts to use technology in a manner consistent with applicable confidentiality requirements, HIPAA privacy standards, professional ethics, and the protection of client information. Any use of artificial intelligence for documentation will be limited to purposes related to treatment, payment, healthcare operations, or clinical record keeping, unless otherwise authorized by the client or required by law.

By signing this informed consent, I understand and give permission for my therapist to use artificial intelligence-assisted documentation tools to help with clinical note taking and record keeping, while understanding that my therapist remains responsible for the final clinical record.

If you desire to opt out of this service simply do not sign this section opting out of these services.

NOTICE OF PRIVACY POLICIES:

Policy: This information is provided to you in response to federal regulations that took effect April 14, 2003. These regulations were issued by the Department of Health and Human Services of the US Government in response to a law called "HIPAA" which was passed in 1996. We care about your privacy and will always do whatever is necessary to protect it. These regulations are about the privacy of your health and personal information known in the regulations as "Protected Health Information" or PHI. As you continue therapy, we will collect, use and share certain information you have provided. This policy explains how we collect and would use it in complying with federal regulations. It also described your rights as they relate to PHI and stated how we will protect the security and confidentiality of your information.

Sharing Information: we can disclose PHI per federal regulations without an authorization from you under these circumstances:

- o For treatment purposes, such as your physician, or another therapist who may be involved in your treatment.
- o For payment purposes, such as your insurance company or other third-party payer.
- o For healthcare operations, such as to set up or confirm appointments, or share your PHI with our receptionist who is directly involved in the business aspect of billing and information.
- o To communicate with family members or friends whom you designate as being allowed to receive this information.
- o For public health reporting purposes.
- o In cases of suspected abuse of the handicapped, elderly, or children.
- o To avert a serious threat to health or safety.
- o For health oversight activities.
- o For workers' compensation purposes.
- o To business associates, such as answering services, collection agencies, etc. These organizations are required to sign agreements with Natural State Counseling Centers to safeguard and protect your PHI.
- o As otherwise provided by law.

In all other cases, we will disclose your PHI only upon receipt of a proper authorization signed by you or your legal representative, as required by law.

Your Rights: Although your PHI is the therapist's legal property, you have certain rights regarding your PHI. You have the right to:

- o Obtain a paper copy of this notice of information, policy and procedures and informed consent. We will give you a copy at your next meeting if requested.
- o Inspect and request a copy of your counseling record.
- o Request to amend your counseling record.
- o Obtain an accounting of disclosures of your counseling information.
- o Request a restriction on certain uses and disclosures of your information
- o Authorize individuals, including family and friends, access to your counseling information as it pertains to treatment, payments and/or healthcare operations.
- o Revoke your authorization to use or disclose counseling information except to the extent that it has already been disclosed.

Our responsibilities:

- o Maintain the privacy of your counseling information.
- o Provide you with this notice of our legal duties, privacy practices with respect to information we collect and maintain about you.
- o Abide by the terms of this notice.
- o Notify you if we are unable to agree to a requested restrictions

Faith Integration Preferences

Faith Integration in Counseling:

Natural State Counseling Centers respects that each client has unique values, beliefs, cultural background, spiritual experiences, and personal convictions. For some clients, faith and spirituality are an important part of healing, growth, identity, relationships, and decision-making. For other clients, faith may not be something they want included in counseling. We honor both.

Faith integration in counseling is always client-centered and based on the client's stated preferences. Your therapist will not impose religious beliefs, spiritual practices, Scripture, prayer, or faith-based perspectives into counseling unless you request or consent to this as part of your care. You may change your preference at any time.

Please indicate the level of faith or spiritual integration you would like included in your counseling:

Faith Integration Scale

0 – No faith integration

I do not want faith, spirituality, religion, Scripture, prayer, or spiritual discussion included in counseling.

1 – Minimal faith awareness

My therapist may be aware of my faith or spiritual background, but I prefer that counseling remain primarily clinical and not include direct faith integration unless I bring it up.

2 – Client-led faith discussion

I am comfortable discussing faith, spirituality, or religious concerns when I bring them up, but I do not want the therapist to initiate faith-based interventions.

3 – Moderate faith integration

I would like faith or spirituality included when clinically appropriate. This may include discussion of spiritual beliefs, values, meaning, forgiveness, grief, hope, relationships, or coping.

4 – Active faith integration

I would like faith actively integrated into counseling when appropriate. This may include Scripture, prayer, spiritual reflection, faith-based coping skills, discussion of theological concerns, and connection between faith and emotional healing.

5 – Primary faith-integrated approach

I would like counseling to intentionally and consistently include my faith as a central part of treatment,

while also receiving clinically appropriate mental health care.

My preferred level of faith integration is:

0 1 2 3 4 5

My faith, spiritual tradition, denomination, worldview, or belief system that I would like respected and/or integrated is:

Specific practices, topics, or resources I would like included, if clinically appropriate:

Examples may include Scripture, prayer, devotional reflection, pastoral counseling perspective, spiritual formation, lament, forgiveness, church concerns, religious trauma concerns, spiritual coping, or other practices.

Specific practices, topics, or approaches I do not want included:

By signing this informed consent, I understand that faith integration is optional, client-directed, and may be changed at any time. I also understand that counseling services remain professional mental health services and are not a replacement for pastoral care, medical care, or spiritual leadership from my chosen faith community.

We reserve the right to change our practices and to make new provisions effective for all PHI we maintain. Should our privacy policy change, we will provide you with an updated copy of such information. We will discontinue to use or disclose your counseling information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to report a problem: if you have a question, you may contact your therapist or the Natural State Counseling Centers Office. If you believe your rights have been violated, you can file a complaint with the Office of Civil Rights with the US Department of Health and Human Services (address listed below) and/or the Arkansas Board of Examiners in Counseling: 101 E. Capitol Ave. #202; Little Rock, AR 72201. There will be no retaliation for filing a complaint.

Office of Civil Rights
US Department of Health and Human
Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

I acknowledge that I have read the statement of disclosure, the complete informed consent, policies and procedures, general information and Notice of Privacy Policies per Federal Regulations. I understand it and I will take responsibility to speak with my clinician if I do not.

By my signature below, I allow Natural State Counseling Centers Counseling to provide counseling to myself and/or my child. I give consent to file my insurance claims (if applicable) following federal regulations regarding my payment and healthcare operations.

Client (or parent/guardian) Date

Client (or parent/guardian) Date

Name of Minor & DOB Date

Counselor/Therapist Date

SCHEDULE OF FEES

_____ **Payment Policies:** Your full payment is due at the time of service. We accept all major credit cards. In order to begin services, we require a valid card to be held on file in our encrypted system. We accept insurance, checks and cash as well.

Health Insurance: if we agree that we will file your claims, we will need a copy of your insurance card. You will be liable to pay your co-pay and we will bill your insurance company for their portion. While we make every attempt to utilize your well-earned insurance benefits, you are ultimately responsible for your bill, not your insurance company. We have no control or knowledge over what insurance companies do with the information submitted or who has access to that information. You must be aware that submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality, privacy or to future eligibility to obtain health or life insurance.

Initial Intake Assessment	\$210.00
Individual Therapy (50 min)	\$190.00
Marital Therapy (50 min)	\$190.00
Co-Parenting (50 min)	\$190.00
*private pay only	
Distance Counseling (50 min)	\$190.00
Individual Therapy (50 min)	\$190.00
*private pay only	
Marital Therapy (50 min)	\$190.00
*private pay only	
Late Cancellation (less than 24 hours) Up to this amount based on therapist license	\$190.00
Records Fee	\$75.00
Official Correspondence (per document)	\$190.00
Meetings with Attorneys (per hour)	\$250.00
LAC Therapy Rates (50 min)	\$90.00
Intern Therapy Rates (50 min)	\$30.00

Court Testimony: Please understand that court fees are not covered by third-party payers and are the full responsibility of the client. Payment is expected on or before the date of service. Travel, meals and lodging will be additional expenses when necessary. Note that this is charged in addition to meetings/depositions with attorneys.

0-4 hours (including travel, court breaks, and waiting in lobby) \$2,500

4-8 hours (including travel, court breaks, and waiting in lobby) \$5,000

Court appearance with less than 5 working days notice \$3,000 (This is in addition to the above fees)

Attorney consultations \$ 250.00/hr

I HAVE READ THE NATURAL STATE COUNSELING CENTERS PAYMENT POLICIES AND AGREE TO PAY IN FULL WHEN SERVICES ARE RENDERED.

Client (or parent/guardian)

Date

Printed name: _____