KELLY VIERRA, LCSW
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INFORMED CONSENT

Thank you for choosing Kelly Vierra, LCSW.

Today's appointment will take approximately 50-55 minutes. 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 our best to give you all the information you need. Kelly Vierra, LCSW has earned a Bachelor of Arts Degree in Psychology and a Masters Degree in Social Work from the University of Illinois at Chicago. I am licensed by the State of Illinois as a Licensed Clinical Social Worker. I have nine years of clinical experience in treating adolescents and adults using individual therapy. I practice standard Person Centered, Solution Focused, Psychodynamic and EMDR therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan imitations 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 (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you are determined to be a clear and present danger to yourself or others, developmentally or intellectually disabled then I am mandated to report you to the Department of Human Services e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call me and request a return call. 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. I, Kelly Vierra, LCSW, will follow those emergency services with standard counseling and support to the client or the client's family. 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: As a courtesy, I will bill your insurance company, responsible party or third-party payer for you if you wish. I ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, I request that you pay the balance due at that time. If your balance exceeds $300.00 I will need to ask that you pay for services when rendered. I ask that every client authorize payment of medical benefits directly to Kelly Vierra, LCSW

I have received a copy of my fee schedule _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at $60.00. I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, 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, we would like your permission to communicate with your primary care physician and/or psychiatrist. 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(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_____

May I contact you at home (circle one) **yes no**? May I contact you at work **yes no?** May I contact you by cell phone **yes no?** Where may I contact you _____?

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ maybe treated as a client by Kelly Vierra, LCSW. 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(s)_____Date_____

Kelly Vierra, LCSW 5/17
Updated 2/19