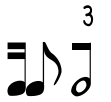

Linda K. Lute, LAC, MAC
Informed Consent

You are entering a therapeutic relationship with Linda Lute, LAC, MAC and I will maintain ownership of your client record. I am a Licensed Addictions Counselor in the State of Colorado, and also hold the national Master Addiction Counselor credential. I have 28 years of experience in the behavioral health field working in a variety of health care settings, including a private psychiatric hospital, non-profit crisis center, homeless shelter, group home, and community behavioral health center, serving all age ranges and economic backgrounds. I hold a Masters' degree in Leisure Studies and Substance Abuse Counseling from Pennsylvania State University and I am committed to partnering with individuals to bring about positive change incorporating work with mind, body, and spirit. Counseling can prove helpful in assisting you to resolve problem areas in your life. Although no one can solve your problems for you, counseling is usually quite successful in helping people cope with challenging life issues.

Client Rights:

• You have the right to decide not to receive counseling, and I can provide you with the names of other qualified therapists if you so desire.
• You have the right to end your therapy at any time.
• You have the right to ask questions about procedures used during therapy sessions.
• You have the right to ask questions about the counseling techniques and to decline the use of certain therapeutic techniques if you feel uncertain of them.
• You have the right to participate in setting treatment goals and evaluating progress toward meeting them.
• You have the right to have all that you say treated confidentially and be informed of the State Law placing limitations on confidentiality in the counseling relationship. Under certain circumstances, I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. See Client Confidentiality section below for details.

Client Responsibilities:

• Set and keep therapy appointments. Appointments scheduled and **cancelled without at least a 24-hour notice are subject to 50% charge.** Exceptions for cancellations are rarely accepted, however the following emergencies are considered:

- Severe illness of yourself or your child requiring immediate or emergency medical/behavioral health care;
- Sudden death of a family member; or
- Inclement weather (ex: severe snow storm leading to closure of public agencies in the immediate office area)

• All fees are paid in cash or by check at the time of service. Returned checks carry a penalty of $25 paid in full prior to scheduling the next appointment. I am also an approved therapist to provide services through the 6th Judicial District Victim's Compensation funds.
• Help plan your therapy goals.
• Keep your therapist informed of your progress toward meeting your goals.
• Inform your therapist of any problems or life circumstances you have which may have an effect on your progress or which may be potentially harmful to yourself or others.

Client Confidentiality:

• You understand that there are certain circumstances when the confidential nature of our counseling sessions may not be honored. Specifically these are:

1. When you disclose that you are the perpetrator or victim of child abuse;
2. When you make a threat toward your own or someone else's physical health and/or safety (this may include sexual behavior or drug use that may expose you to the AIDS virus);
3. Local, State or Federal law and/or the Court requires disclosure;
4. You give us your written authorization.

a. If you provide us your written authorization to communicate with others outside your presence, you may revoke it any time. However, you understand that we cannot take back any uses or disclosures already made with your permission.

In addition to your intake paperwork I will keep a record of our sessions in some manner and this information is kept in your file and considered confidential information. Your file is the property of this therapist. If you desire any information from your file you may make a request in writing and the information will be provided to you within a convenient time frame. If you are involved in a Court proceeding, my files will not be made available to anyone other than you, unless subpoenaed. My file may be vulnerable to being subpoenaed by other interested parties.

Professional Relationship

Your relationship with the therapist is confined to and/or defined as a professional counseling relationship. I am prohibited from engaging with you in any additional social or economic relationships. If such a relationship exists at the time that you begin counseling with me, an addendum to this statement will need to be signed, outlining the existent relationship. If no such prior relationship exists, our relationship cannot be expanded to a social or economic relationship once counseling has begun. Specifically, we agree that the therapist will limit their elationship with you to that of behavioral health counselor.

Risks and Benefits of Therapy

Psychotherapy may involve the risk of remembering unpleasant events and can arouse intense emotions of fear, anger, anxiety, depression, frustration, loneliness or helplessness. The benefits from therapy may be the ability to better able to handle or cope with family or other social relationships, thus experiencing more satisfaction from those relationships. Another possible benefit is a better understanding of personal goals and values, which may lead to greater personal maturity and growth. Your therapist is not a physician and cannot prescribe medication or perform any medical procedures. If medical treatment is indicated, you can choose the physician of your choice or receive potential referrals. I cannot guarantee the goals of therapy will be attained; however, I will in good faith attempt to apply all the knowledge and resources I have to help you attain your therapy goals. You should know there are possible risks of greater emotional discomfort/distress being the end result of counseling. There is no guarantee, expressed or implied, and no refund of any money paid, due to non-results and/or undesired results due to the counseling you have received.

Therapist Availability

Emergency situations do arise when you may need to speak with your therapist by telephone in between appointments. The size of my practice limits my ability to respond to such emergencies in a timely manner. You are entering into our counseling relationship with this understanding, and are accepting the level of service I can provide with the implied limitations. Specifically, when I am unavailable for whatever reason, it will be your decision to wait for a return call which may take several days (or longer on occasion), or assume the responsibility to find an alternative source of assistance (in life threatening situations, a call to 911 is often your best option). If you are unable to contact me and the situation requires immediate attention, please be aware that you can seek emergency treatment at a local emergency room. Be advised, however, that you will be responsible for any and all expenses you may incur by using their services.

Appointment Cancellations

Each 50-minute individual, couples, or family counseling session will be billed at a rate of $100, unless other arrangements are made prior to beginning the therapeutic relationship. Group fee is $40 per group. Payment for each counseling session will be made at the start of each session. Payments made by check need to be made out to Life Path, LLC. Please have checks made out ahead of time. We do not employ a receptionist so payment will be collected by your therapist. A sliding fee scale may be available upon request. If at any point in time you become unable or unwilling to continue paying for services, I reserve the right to terminate our If you need to change or cancel appointments, please do so a minimum of 48 hours in advance. Appointments not cancelled within 48 hours will be billed at half the session rate. Counseling sessions are scheduled and billed in 50 minute increments regardless if they are less than 50 minutes in length. There may be consideration given to a need to schedule sessions that run longer upon request. This would generate an additional fee. Please be advised that there will be a fee charged for any phone call returned to discuss anything other than the changing of appointment times. Telephone consultations and requested written reports are billed in 15 minute increments, at a rate of $25.00 for every 15 minutes. Fees for work done outside a regularly scheduled appointment will be payable in full prior to

your next appointment. I do not bill insurance companies. If you would like a bill to provide your insurance company or health care flexible spending fund, please make me therapist aware of this need and a bill can be sent to you at the end of each month.

Returned Checks
Any check not honored by your bank for any reason will result in a $25 returned check fee. Returned checks, in some cases, may or may not be processed by the bank twice before deemed insufficient. Returned checks must be paid by cash or money order. Failure to pay any returned check and fees may result in criminal prosecution.

Legal
Should you become involved in the legal system for any reason, it is important you understand the following seven points:

- I will not be called upon to furnish records or testimony until all fees for services are agreed upon.
- I request 20 days prior notice for any court appearance. Due to the nature of my practice, I cannot guarantee availability to appear in court even with the given notice.
- Depositions and/or any type of testimony related to the therapeutic relationship is compensated at a rate of $250.00 per hour, with a two hour minimum.
- Any subpoenas requiring testimony should be accompanied by a check for a minimum of $250.00. All such fees are usually paid by the party issuing the subpoena, unless otherwise negotiated.
- In connection with any subpoena request for copies of any part of my records, I request 10 working days advance notice to comply. Additionally, such requests should be accompanied by a check for $25.00.
- You agree that under no circumstances shall I be required to attend any court session, give any testimony in any hearing, or provide records to any person, until I have been paid in full for all services. You agree to instruct your attorney to abide by this requirement as well.

Please initial the following items to acknowledge your understanding and consent.
_____ Notice of Clinical Consultation
Your therapeutic treatment needs may be discussed during clinical consultation with another licensed therapist. If at any time you become uncomfortable with this practice, you are free to terminate counseling and be referred to another counselor.

_____ Informed Consent
You acknowledge the following:

- You are entering into an agreement for psychotherapy services voluntarily, and you are free to discontinue services at any time at your discretion.
- You understand that I may discontinue services at any time if the continuation of services becomes clinically, legally, ethically, or in any way inappropriate. If that occurs, you understand that Iwill m ake a good faith effort to help you obtain other appropriate services.
- You have read and understand the client rights and responsibilities listed above.
- You have read and understand the potential risks and benefits of psychotherapy services.
- You understand that the services provided for treatment are not guaranteed to be effective.
- You understand that I am required by law to report suspected or known child abuse, intent to harm yourself or someone else, inability to care for your basic needs, or any sexual relationships between a client and another mental health professional.
- You have read and understand the limits of client confidentiality.
- You understand that I do not provide medication management.
- You understand that I do not provide 24-hour response crisis management services.

_____ HIPAA Acknowledgement
I hereby affirm that I received and read the Privacy Practices HIPAA Notification form and understand the information.
Acknowledgement

____ **Consent for Treatment:** By initialing this section and participating in scheduled appointments you are consenting to treatment. This may consist of various modalities including individual or couples counseling, group

therapy and/or family therapy with the goal of stabilizing current stressors and associated symptoms. As treatment progresses and difficult issues are discussed levels of stress and tension may also rise. Likewise, the benefits of treatment may include improved levels of functioning, self-confidence and self-esteem, etc. It is important for you and the therapist to work together in managing these ups and downs. In addition, continued treatment is your decision. I may make recommendations for ongoing treatment based upon your progress. If you cancel or miss a scheduled appointment and do not contact me for thirty (30) or more consecutive calendar days; and/or do not respond within five (5) calendar days to my attempt to make contact, it is understood that you have terminated treatment against medical advice.

By signing this form, you are acknowledging that you have read all four pages of this material, and accept it as outlining the conditions upon which counseling is provided. Your signature further attests that you have had an opportunity to receive a copy of this information for your personal records. Everyone receiving counseling services must sign this document.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date