Consent for Treatment

_____: Valentine Counseling Services team (VCS team) and services offered as such:

- Offers sessions for individual, couple, and/or family therapy
- Makes appropriate referrals according to professional standards of practice if more in-depth psychotherapy or medications are needed
- Expects that you **call 911** or *go to the nearest hospital emergency room,* or text "MN" to 741 741 for immediate text response in case of emergency

_____: VCS team will keep a confidential file about my/our appointments and proceedings. Release of confidential information requires my/our signature on a statement of release with the following notable exceptions:

- Significant indicators that a minor/child or vulnerable adult is being abused or neglected
- Significant indicators that a pregnant female is abusing drugs
- Significant indicators of a clear and present danger to the health and safety of an identifiable individual (you or someone else)
- If a court of law issues a legitimate court order (signed by a judge), VCS team is required by law to provide the information specifically described in that order
- Results of treatment for court-ordered therapy must be revealed to the court
- If you choose to pay through insurance, your insurance can request your records at any time

Should VCS team find or have reasonable belief that any of these above conditions are present, I/we expect that they will break confidentiality in order to protect me/us and/or others.

_____: Your situation may be reviewed during consultations with other mental health professionals / providers in order to provide you with the best possible ongoing services. *Identifying information will not be disclosed.*

_____: VCS team will not participate in testifying for or against either one of you, nor will they voluntarily or involuntarily participate in any court proceedings you may be a party to in any court in this state or elsewhere.

_____: Fees:

- 55-minute sessions: $________ for individual, $________ for couple or family
- 80-minute sessions: $________ for individual, $________ for couple or family
- Full, deductible, or co-payment is to be made by cash, check, or card due at each session
- Tele-therapy is billed at the full, private pay rate

_____: I understand these rates may change at any time and I will responsible for payment.

_____: I am electing to self pay and not bill insurance for services at this time.

_____: Cancellations, no-shows, unpaid balances:

- Cancellations or changes must be arranged 24 hours in advance
- Cancellation or No-show fee is $75.00, which must be paid before scheduling future appointments
- Running a balance is not permissible

- VCS team has the right to seek legal recourse to recover any unpaid balance which requires disclosing personal information

_____: There is no guarantee that benefits will be received from individual, couple, and/or family therapy. In addition, while exploring personal issues and making life changes, you might experience emotional pain, discomfort, and anxiety. You have the right to decide what to talk about and work on in and out of therapy. Nevertheless, your active participation will have the greatest positive effect on the outcome of therapy.

Your signature(s) and initials indicate that you have had the opportunity to ask questions, had questions answered to your satisfaction, understand and agree to these terms, and are aware that you are free to discontinue services at any time.

This Consent is in effect until the end of treatment.

Signature Date

Signature Date

Signature Date

Traci Valentine, M.Ed LMFT Minnesota License #2187 Valentine Counseling Services Phone: 651-373-3886	