# BOWLING COUNSELING CENTER INFORMED CONSENT

Thank you for choosing Bowling Counseling Center. Today's appointment will take approximately 45-50 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 my best to give you all the information you need. Lynn Bowling MS, NCC, LPCC has earned her Bachelor of Science Degree in Psychology, and a Masters Degree in Counseling from Troy University. Lynn is a Nationally Certified Counselor and is Licensed by the State of Kentucky as a Licensed Professional Clinical Counselor. Lynn has over 23 years of clinical experience in treating adolescents, adults, and families using individual, and family therapy. Lynn Bowling practices Cognitive Behavior therapy for most conditions, although other treatment approaches may be used depending on the person, condition, or situation. Treatment practices, philosophy, plan limitations, and risks will be discussed with you today.

**CONFIDENTIALITY AND EMERGENCY SITUATIONS:**

Your verbal communications 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 your child or children report about physical or sexual abuse; then, by Kentucky State law, I am obligated to report this to Social Services, c) where you sign a release of information to have specific information shared, and d) if you provide me information that informs me that you are in a danger of harming yourself or others, e) information necessary for case supervision or consultation and lastly, 1) or when required by law. If an emergency situation for which the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Lynn Bowling will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____ Date:. _____

**FINANCIAL/INSURANCE ISSUES:** As a courtesy, I will bill your insurance company, HMO, responsible party or third party payer for you if you wish. I ask that at each session you pay your co-payor 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; 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 our 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 Lynn Bowling.
**Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate.** I sincerely appreciate your cooperation and if at any time you have 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:. _____

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**COORDINATION OF TREATMENT:** 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.** If you prefer to decline consent, no information needs to be shared.

_____you may inform my physician (s) _____ I decline to inform my MD

**PHYSICIAN NAME: _____**

**CLINIC: _____**

**ADDRESS: _____**

**PHONE: _____**

Signature(s) _____ Date:. _____

**CONSENT FOR TREATMENT FOR ADOLESCENTS:** I/We consent that _____ may be treated as a client by Lynn Bowling. At times, it may be necessary to schedule appointments during school hours. I ask for your cooperation to provide the timeliest treatment for you and your adolescent.

Signature(s) _____ Date:. _____