

Jeffrey Hubbell Therapy
Jeffrey Hubbell, LMSW, LSCSW
Phone Number: 314-482-1860

Client Name: _____

Consent to Treatment, Client Rights and Responsibilities

The following outlines the agreements and conditions of therapy services for yourself and/or your minor child. Please read this form in its entirety, respond to Question 7 (regarding primary care physician) and sign at the end of the form.

You have the right to: Be informed of your therapist's procedures, risk of treatment and therapeutic style; Be informed of your therapist's qualifications and professional limitations; Request a referral for a second opinion; and Participate in treatment planning as well as termination treatment at any time with a request for a referral, if desired. You are responsible for terminating your counseling relationship prior to entering into therapy with another therapist, unless special circumstances, agreed upon by the client and the new therapist warrant otherwise.

1. I hereby consent to participation in necessary mental health counseling services with Jeffrey Hubbell, LSCSW. I understand that I participate on a voluntary basis and that I or Jeffrey Hubbell, LSCSW may discontinue services at any time.

2. I understand that Jeffrey Hubbell, LSCSW is a Licensed Clinical Social Worker in the states of Kansas and is required to adhere to the National Association of Social Workers Code of Ethics.

3. I understand that Jeffrey Hubbell, LSCW is not licensed to practice medicine or prescribe medication. I will be referred to a qualified physician and/or psychiatrist for medication evaluation and/or management deemed necessary by my therapist.

4. I have had the billing practices of my counseling services explained to me to my satisfaction and understand the fees for these services. I understand that I am responsible for payment of fees at the time of service.

5. I understand that all files are kept confidential. My written consent is required for any release of information by my clinician to other persons or agencies except in the following situations:

- a) Concerns of abuse/neglect of minors, vulnerable adults or elders
- b) Life threatening situations (including concerns of harm to self or others)
- c) When a court order/subpoena signed by a judge has been received.

6. I understand that no guarantees have been made to me about the outcomes of my treatment.

7. Most sessions are 30-60 minutes. If you are late for a session, we will meet for the time you have left. If Jeffrey Hubbell is late, she will make the time up to you.

8. If the presenting client is a minor, he/she/they is seen only with permission from his or her parent(s) or guardian. For minor clients, a parent or legal guardian should remain on the facility grounds (in waiting room or parking lot) while the child is in the session. Parents are encouraged to respect their minor child's right to confidentiality. The specifics of therapy conversations with minors will be kept private. Parents can be assured that the minor will be encouraged to share critical information and parents will be given information regarding therapy themes and treatment process. Laws regarding disclosure as specified previously also apply to minor clients. Minors of divorce must have permission from the custodial parent to attend counseling. Permission from

both parents, regardless of the custodial arrangement, is the preferred practice of this office. A copy of the divorce decree must be included in the client file indicating the custodial arrangement. In any custodial arrangement, both parents have the right to contact the therapist and inquire regarding the minor's treatment progress (unless otherwise specified by the courts).

9. In mental health emergencies, call Comcare crisis, 316-660-7500 or take yourself/or your minor child to the nearest emergency room. You may also call the following crisis number, 988

10. I have been provided a separate sheet outlining the fee schedule. I accept the fee conditions and recognize that I am responsible for any services provided by Jeffrey Hubbell, LCSW. I am aware that accounts that are 90 days past due may be turned over to collection.

No Show/Late Cancellation Policy (updated August 16, 2022): Should you need to cancel or reschedule an appointment please contact your therapist as soon as possible, and no later than 24 hours prior to your scheduled appointment. This allows time to schedule other clients who may be waiting for an appointment. Any established patient who fails to show or cancels/reschedules an appointment and has not contacted the therapist with at least 24 hours notice will be considered a No Show and charged a \$50.00 fee. If there is a second incident, the client will be charged the full fee of service scheduled. The third incident will result in a discussion about continued services and may result in a 3 month pause of services. The fee is charged to the patient, not the insurance company. Any new patient who fails to show for their initial visit will not be rescheduled.

My signature below indicates that I have reviewed this form and had the opportunity to discuss any questions or concerns regarding it with my therapist.

Client signature or Parent/Guardian signature for minor

Date