PEGGY L. FERGUSON, PH.D., LADC, LMFT

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CONSENT FOR UTILIZATION OF COUNSELING SERVICES

DATE:_____ CLIENT NAME(S)_____

I hereby voluntarily consent to utilizing the services provided by Peggy L. Ferguson, Ph.D. I realize that Dr. Ferguson is an internationally certified and state licensed alcoholism/drug addiction counselor and licensed marriage and family therapist whose specialty is working with recovering alcoholics/addicts and their families, and is not a psychologist, psychiatrist, or social worker.

I understand that I have a right to ask questions regarding the methods, duration, and goals of counseling, the right to discuss any concerns I may have about my progress in counseling, and the right to terminate counseling if I feel that I am not making progress.

I understand that one of my most important rights involves confidentiality. Within certain limits, information revealed by me during counseling will be kept strictly confidential, and will not be revealed to any other person or agency without my written consent. I understand that the name(s) and phone number(s) of the person(s) I supply as emergency contact(s) may be contacted in case of any kind of emergency, whether physical injury or illness or in case of emotional, psychological, or therapeutic emergency. I also understand that there are certain limits to confidentiality as specified by law and/or professional ethics. Some of the limits to confidentiality include a) a client threatening bodily harm or death to another person, b) a client expressing serious intent to grievously harm him/herself, c) a court issuing a legitimate subpoena, d) a counselor has good reason to suspect that a child is a victim of physical or sexual abuse or neglect. I understand that under the above conditions (and others), the counselor is duty bound to break confidentiality.

I understand that any assessments, evaluations, or records made or kept in the course of treatment are not intended for forensic (court) purposes, including social security hearings. All such assessments and record keeping are designed for clinical purposes only.

I understand that Dr. Ferguson charges $135.00 per <u>fifty-minute</u> individual and family sessions. The first session, a history and evaluation session is charged at $195.00 per fifty-minute session. Payment is expected at the time that services are rendered (with exception). I further understand that “late hours” appointments are available on a limited basis and that these appointments (5:00 and 6:00 p.m.) carry an additional fee of $10.00 per session, which is not billed to the insurance company and that I am personally responsible for.

I further understand that I must give twenty four hour notice if I wish to cancel an appointment, or a $75.00 cancellation fee will be charged, which I, (not the insurance company) will be expected to pay. I also understand that written reports (with appropriate signed releases) requested by me, my insurance company, or some other party designated by me, will be charged

at $100.00 per hour, which is payable by me. Insurance may be filed for counseling sessions (once per claim) **as a courtesy to the patient**. Patients are responsible for the part that their insurance does not pay (including deductibles, co-pays, not covered charges, out of pocket charges and any other charges) and are responsible for problem solving with their own insurance companies over disputed benefits or payments. I understand that I am responsible for understanding the contents, requirements, and limits of my coverage and will make informed decisions about seeking and continuing services that may not be covered by my insurance.

I understand that my counseling can be terminated for delinquent account and that delinquent accounts may be turned over to collection agencies and/or credit reporting companies. I understand that Dr. Ferguson may release information in order to collect any unpaid balances after termination of counseling, but that any release of information for this purpose will not involve release of clinical information (other than identification as being in counseling) without expressed written consent.

I understand that Dr. Ferguson is not available 24 hours per day, seven days per week and in the event of Dr. Ferguson's lack of availability during a psychological/emotional crisis, I will contact my local hospital emergency room or crisis management service facility.

I further understand that if I am signing consent for services for a minor, that I will be financially responsible for services rendered while they are/were a minor. Even if I am not a minor, I understand that Dr. Ferguson may require a co-signer for financial responsibility for the charges I incur in counseling.

I also understand that there is no guarantee that I will achieve my desired results from counseling.

I certify that I understand the contents of this document, and I give my consent for counseling services.

_____ _____

Client Counselor

_____ _____

Client Date signed

_____

Client

_____

Parent or guardian for minor

_____I would like for Dr. Ferguson to contact me after completion of my counseling to inquire about me, to send cards, newsletters, etc., or to participate in outcome assessment (how well counseling worked for me).

____ I would **not** like for Dr. Ferguson to contact me after completion of my counseling.

Revised 10.23.12