

**Professional Counseling Associates, LLC**  
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**Nicholas Rudgear, MC, LAC, NCC**  
*Licensed Associate Counselor*

## **Informed Consent for Assessment and Treatment**

I want to welcome you to our practice at Professional Counseling Associates. I am pleased you have chosen our services. In order to assist you in understanding the rights, responsibilities, and expectations involved in the counseling relationship, please read and sign the following informed consent. During our initial meeting, we will review this consent agreement and discuss any questions you may have. Additionally, I will provide you with a copy of this consent at any time should you request it.

I am a Licensed Associate Counselor (LAC) by the Arizona Board of Behavioral Health Examiners as well as a Nationally Certified Counselor (NCC) by the National Board for Certified Counselors. I have earned a Master's Degree in Counseling from Arizona State University. My professional practice includes individual, family, and couple's counseling. I specialize in trauma/abuse, grief and loss, and mood disorders (anxiety, depression, etc). I utilize an eclectic approach to therapy, drawing from many different modalities and perspectives, and I am also an EMDR trained therapist.

I am currently working on obtaining full AZ state licensure as a Licensed Professional Counselor. During this process, I will be under the direct supervision of Dr. John Michael, PhD, LPC and Dr. Raymond Branton, PsyD, LP. I participate in a process where selected cases are discussed with other professional colleagues to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released in this peer consultation process, the dynamics of the problems and the people are discussed along with the treatment approaches and methods. As a client of Professional Counseling Associates, your case will be reviewed and discussed with my supervisors in a confidential manner on a routine basis. If you have any questions or concerns, Dr. John Michael, PhD, LPC and/or Dr. Raymond Branton, PsyD, LP, can be reached by calling the phone number listed above. I reserve the right to refer a client to another therapist, or appropriate resource at any time, if his or her needs in therapy are not a good match for my skills or experience.

One of the distinctive aspects of my practice is my belief that there is a spiritual component or dynamic to life, including current challenges or concerns that may be your reason for seeking counseling. *It is not essential that my clients share my Christian beliefs, but you have a right to know that my value assumptions are rooted in my faith in Christ. That being said, I am committed to providing a safe environment in which my clients experience the freedom to explore their own beliefs, experiences of spiritual and cultural traditions, and make their own choices regarding life and relationships.* Additionally, I am committed to provide quality professional Christian counseling to those who have expressed desire for such an emphasis.

### **Financial**

Payment is expected at the time the service is rendered. By signing this document, you are agreeing to pay for the services rendered and any additional expenses that may be accrued in collecting said fees. Currently, the fee for an initial assessment is \$95.00, and the fee for a 50-minute counseling session is \$95.00. In addition to the basic session and assessment fees, there may be other fees for additional services such as

psychometric testing, telephone counseling, email correspondence, books and materials, etc. If professional services provided are less than the per hour rate, the services will be billed out at an incremental rate of 15 minutes. There will be a \$35.00 fee for checks that are returned as non-sufficient funds or non-payable. I reserve the right to change my fees with 30 days' notice. You have the right to be informed of all fees that you are required to pay and our refund and collection policies. Please discuss these with me if you have a concern.

### **Insurance**

I currently do not bill insurance companies. If you are using an insurance program, I will supply you with a superbill that you can turn in to your insurance company for possible reimbursement. In all cases, however, payment for services is due at the time of service and is ultimately the responsibility of the client, not the insurance company.

### **Availability of Services / Emergencies**

Our practice does **not** have the capability to respond immediately to counseling emergencies. True emergencies should be directed to the community emergency services (911) or to the local hotlines (Empact – 480-784-1500, Banner Help line - 602-254-4357, Crisis Response Network– 602-222-9444). Established clients with an urgent need to make contact may contact me and every effort to respond as soon as possible will be made, but an immediate response is not guaranteed. A quick or immediate response in one situation does not constitute a commitment of rapid response in another situation. In any crisis situation, crisis and/or emergency services should always be utilized first.

(initials) \_\_\_\_\_ If I ever feel like I want to hurt myself or someone else, I agree that I have received a copy of this consent form and safety information with resources to getting more immediate help.

### **Appointments**

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in counseling. I reserve 50 minutes for each appointment with a client. Appointments canceled at the last minute are very detrimental to my practice. Therefore, I ask that you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. ***You will be financially responsible for appointments you fail to cancel in accordance with this policy. Our office is not able to do reminder calls. Therefore, please make a note of the date and time of your next appointment, whether it is made over the phone or in person.***

Appointment availability varies with the client load at the time. High demand appointment times are likely to be sporadic in their availability. I reserve the right to limit our commitments of high demand appointment times to any particular client in order to meet the needs of all my clients and balance my workload.

### **Privacy, Confidentiality, and Clinical Records**

All communications and records created in the process of counseling are held in the strictest confidence. However, there are numerous exceptions to confidentiality defined in the state and federal statutes. Examples of the most common of these exceptions are:

- when a real or potential life or death emergency is suspected;
- when a judge issues a court order for client records;
- or when child, vulnerable adult or elder abuse or neglect is suspected.

Please note, a civil subpoena issued by an attorney does not automatically guarantee the release of records. In most instances where a subpoena has been issued, the client must still sign a release of information authorizing the release of records.

Additionally, information may be released including when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against us, to comply with worker compensation laws, to comply with the USA Patriot Act and to comply with other federal, state or local laws. The rules and laws regarding confidentiality, privacy, and records are complex.

The HIPPA NOTICE OF PRIVACY PRACTICES, is available for your review if you request it. This packet also contains information about your right to access records and the details of the procedure to obtain them, should you choose to do so. Periodically, the HIPPA NOTICE OF PRIVACY PRACTICES may be revised. It is imperative that you understand the limits to privacy and confidentiality before you begin treatment.

(initial) \_\_\_\_\_ I understand that the HIPPA NOTICE OF PRIVACY PRACTICES and that it is incorporated into this consent packet, and have had my questions about privacy and confidentiality answered to my satisfaction.

You may request copies of your clinical record. Our agency requires a signed written notice before copies of records or in order for records to be sent to another party. Our agency has up to 10 business days to fulfill the request. The fee for copying a chart is \$20 for the first twenty pages and \$0.25 for each additional page.

If I as your counselor ever get seriously injured, ill/incapacitated, need to take an extended leave of absence or suffers from an accident or die and am unable to meet with you, a representative from Professional Counseling Associates and/or Dr. John Michael, PhD, LPC / Dr. Raymond Branton, PsyD, LP will become my conservator(s) of my client records. They would contact you to inform you and discuss the way forward.

### ***Couples / Co-Therapy***

If you are married and primarily seeking marital counseling, a single chart will be created in both spouses' names. Please be aware that if records from a joint marital chart are requested by any party or entity in the future, the signatures of both spouses must be obtained in order to voluntarily release any information. If you are a married couple seeking marital counseling and you would prefer separate charts in each of your names, please specifically request this and every effort will be made to accommodate your request.

By signing this Agreement, you are agreeing that any information you disclose is acceptable to share with the other spouse or other client(s) in the treatment process with you. In other words, in marital counseling or co-therapy, secretive information will not be confidentially held between one of the clients and Nicholas Rudgear and subsequently withheld from the other spouse; Nicholas Rudgear will not agree to hold any secretive information between the spouses. Unless Nicholas Rudgear believes that there is imminent danger to one of the spouses if the disclosed information is shared, all information shared by each spouse is free to be shared with the other spouse, even if that particular information was originally shared in an individual session or by phone or email. If you have any questions regarding this ethical stance and preference, please ask me before you sign this agreement.

### ***Electronic Privacy and Security Matters***

Please utilize e-mail/text at your will and discretion, as the server is a non-encrypted server and therefore you must assume no confidentiality. It is recommended that you provide minimal identifying information in the

body of the message, and provide only the details you feel necessary. Responses to e-mails/text will be as thorough as needed to appropriately and fully address the inquiry. In cases of inquiries of a clinical nature, I will respond with a request to come in to the office to discuss the matter in a scheduled session. This policy not only protects your confidentiality but also allows us to handle sensitive matters in an ethically responsible manner. Please note that e-mails/text are an acceptable way to schedule or change an appointment time, and a confirmation e-mail/text will be sent to you after an appointment has been scheduled or changed by you.

Furthermore, progress notes and other chart records may also include phone and email communication between the client and me, office staff, and (if a release is signed) with other individuals involved in treatment. Any messages that a client might leave on voicemails, text messages, and/or emails may be printed out or transcribed and entered into the client chart records at any time to ensure proper documentation of any client interactions.

### **Purpose, Limitations, and Risks of Treatment**

Counseling, like most endeavors in the helping professions, is not an exact science. While the ultimate purpose of counseling is to reduce your distress through a process of personal change, there are no guarantees that the treatment provided will be effective or useful. Moreover, the process of counseling usually involves working through tough personal issues that can result in some emotional or psychological pain for the client. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships, or virtually any other aspect of your life. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. In the case of marriage and family counseling, interpersonal conflict can increase as we discuss family issues. Of course, the potential for a divorce is always a risk in marital counseling.

### **Treatment Process and Rights.**

Your counseling will begin with one or more sessions devoted to an initial assessment so that I can get a good understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, we will discuss ways to treat the problem(s) that have brought you into counseling and develop a treatment plan. You have the right and the obligation to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You have the right to ask questions about any procedures used during therapy. You also have the right to refuse any recommended treatment or to withdraw consent to treat and to be advised of the consequences of such refusal or withdrawal. Additionally, you have a right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. The cancellation policy will still apply to any appointments scheduled and not attended. The recording of any counseling session is strictly prohibited without the written consent of the counselor and client. This includes any type of audio or video devices.

### **Our Relationship**

The client/counselor relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a counselor to spend time together socially. The purpose of these boundaries is to ensure that you and your therapist are clear in your roles for treatment and that your confidentiality is maintained. For this reason, I will not participate in social media interchanges. Therefore, attempts to befriend a therapist online will not be accepted. There may be a time when our paths cross outside of the therapy session. I will maintain your confidentiality by making any gesture to you minimal if at all. It will be

understood that you or I are not being rude, simply maintaining the therapeutic boundary. You may approach me if you like, although I will keep conversation minimal, to maintain your privacy.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with us about it. It is never our intention to cause this to happen to our clients, but sometimes misunderstandings can inadvertently result in hurt feelings. We want to address any issues that might get in the way of the therapy as soon as possible. This includes administrative or financial issues as well.

**Consent for Evaluation and Treatment.**

My consent is hereby given for evaluation and treatment under the terms described in this informed consent document. I agree that either party, client or therapist, may discontinue the evaluation and treatment at any time and that I, the client, am free to accept or reject the treatment or referrals provided. I understand that I am consenting to participate in treatment with an associate level counselor and that my treatment will be supervised by Dr. Raymond E. Branton, PsyD, LP, and Dr. John Michael, PhD, LPC. I understand the methods Nicholas Rudgear, MC, LAC, NCC may utilize to aid in the supervision process. In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Additional Signature of Consenting Adult Needed for Minor Child(ren) or for Marital Therapy:

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

In the case of a minor child(ren) or adolescent(s) (under age 18), please specify the following:

Full name of minor: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship \_\_\_\_\_

Full name of minor: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nicholas Rudgear, MC, LAC, NCC AZ License: LAC-16401

For office use only - verification that client has read and understands informed consent document
Authorized Representative: _____ Date: _____
Therapist Name: _____