Debra M. Kraus, M.A., LMHC - Footprints Counseling LLC

First United Methodist Church 275 4th St. N, St. Petersburg, FL 33701

Informed Consent

Please read the following information and sign to indicate that you understand the policies and procedures of Debra M. Kraus, M.A., LMHC.

Therapist Information: I, Debra M. Kraus, hold a Master of Arts degree in Professional Counseling from Liberty University and I am currently licensed by the state of Florida as a licensed mental health counselor. My Florida license number is MH 13279.

- **Services:** I provide many different types of therapy for individuals, families, and couples in addition to specialized group therapy. The length of therapy may vary depending on the collaborative efforts between the therapist and client(s). The goals of therapy are developed with the therapist, are based on client's needs and concerns, and are reviewed periodically to monitor progress. I consider therapy an active process and therefore prefer clients to play an active role in their own therapy. Additionally, my counseling services are voluntary. If the client has been court ordered for therapy, a copy of this documentation must be provided prior to the next counseling session.

- **Appointments:** Regular attendance to therapy is vitally important to ensure progress with the concerns and issues that have been presented. Please make every effort to keep appointments and to be on time. Each individual therapy session is (50) minutes in length. Family and couples' sessions may last as long as 90 minutes. Sessions lasting longer than 50 minutes will be arranged in advance. **If you cancel an appointment, please call 727-458-1080 at least 24 hours prior to the time of your appointment.** Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification.

- **Telephone and Emergency Procedures:** In some instances, you might need immediate help at a time when I cannot return your call. These emergencies may involve suicidal thoughts, thoughts of wanting to hurt someone else, or thoughts of committing dangerous acts. **If you find yourself in any emergency situation, please visit the nearest emergency room of the nearest hospital and ask for a Mental Health Professional or call 911.** If you need to contact me between sessions, please leave a message on my confidential voice mail and your call will be returned as soon as possible. I check my messages several times each day. If I am out of town, I will provide you with the name of a covering clinician.

- **Fees:** **Therapy sessions are to be paid in full before the beginning of each session.** Please be aware the only insurances I accept is BayCare EAP, SAP and Managed Care, ComPsych EAP, TRICARE/Value Options, Logistics Health Inc. EAP, ESI EAP, E4Health EAP, LifeWorks EAP, and American Behavioral Managed Care and EAP, otherwise all sessions will be self-pay. The fee for a 50-minute session is $125.00 with initial evaluation being $140.00; make checks payable to: ***Footprints Counseling LLC.*** Payments can be made with checks, cash or credit card. I do offer reduced fees on a very limited basis. Those clients who can afford to pay the full fee make it possible for me to provide lower cost services to those who cannot. Please keep this in mind. If you wish to obtain a detailed statement/receipt for your own insurance purposes you may request so in writing. This statement will be available for pickup seven days after the official request is made. There will be a $25.00 service charge on all returned checks to be paid prior to your next appointment.

- **Minors:** If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records unless they sign a waiver of these rights which is revocable at any time. Before giving parents any information, I will discuss the matter with you, if possible, and do my best to handle the objections you may have with what we are prepared to discuss.

- **Safety:** It is important that you and your children exercise appropriate caution, control and safe behavior on the premises. This includes no running in the hallways or on the staircase. If the child is outside, a parent or guardian must be present. Debra M. Kraus, or First United Methodist Church of St. Petersburg, Florida are not responsible for any injuries that occur on the premises due to lack of parental supervision. If a child is under 16 years old and is attending individual or play therapy sessions, one parent or guardian must remain on the premises for the duration of the session. If the child is over 16 he or she may drive him or herself after one or more parent/guardian signs a consent form. If the parent of a child 16 years of age or older leaves for the duration of the session, he or she must arrive back to the premises prior to five (5) minutes before the end of the session.

- **Confidentiality:** Your verbal communication and clinical records are strictly confidential except for:

1. Information shared with consultants and supervisors
2. Information (diagnosis and dates of service) shared with your insurance company to process insurance claims
3. If you present a danger to yourself or others, I am legally and ethically required by law to protect the safety of you and/or the threatened person(s).
4. If abuse (sexual or physical) or neglect of a child, elderly, individual, or disabled person is revealed, known or suspected, I am required by Florida state law to report it to the Florida Abuse Hotline.
5. Where you sign a release of information to have specific information shared
6. Or when required by law: if I receive a court order/subpoena for client records, staff deposition or court testimony, I am required to comply. I am also required to report attendance compliance to the court for court-ordered clients.

- **Termination and Referrals:** The first few sessions are for the purpose of evaluation. At the end of this evaluation we will discuss treatment goals and outline a treatment plan. In some cases, I may refer you to another professional. If I do so, I will provide you with a number of referrals that you can contact. If, at any point during psychotherapy, I assess that I am not effective in helping you reach your therapeutic goals I will discuss this with you and, if appropriate, may terminate treatment. If this case I will provide you with a list of referrals. With your written permission I will talk to the other psychotherapist of your choice in order to help with the transition. If, at any time, you want another professional's opinion or wish to consult with another psychotherapist I will assist you in finding someone qualified. The client is expected to inform the therapist of his or her plans to discontinue therapy for any reason and make plans for at least one additional session. The final therapy session is an important part of the therapeutic process to help summarize the progress and appreciate the change and growth that has occurred. If a client does not show up for two of their therapy appointments with no contact with the therapist, the case will be closed. This does not necessarily mean that you cannot receive further services. If you decide to terminate therapy, you are still responsible for payment of any unpaid therapy sessions already received. The therapist may discontinue therapy with the client if there is reason to believe that further services will not be beneficial to the client. If that should occur the client will be referred for appropriate services.
- **Social Media**: Email, text messages, social networking sites (Facebook, Twitter, LinkedIn, Pinterest, Instagram, etc.) and online video chatting (Skype) are not means which confidentiality can be guaranteed. It is my practice not to use these means to communicate or counsel with you. Occasionally, I will send a reminder text message to notify you of an upcoming counseling appointment or an email with documents or other useful information that pertains to your health and well-being. Please understand that I will not go into a "counseling session" with you through these venues; they are not designed to afford you the confidentiality that you deserve and therefore, I do not conduct therapy in this manner.
- **Legal Testimony:** It is my policy not to appear in court in legal proceedings (such as, but not limited to divorce and custody disputes, injuries) and ask that neither you, nor your attorney, nor anyone acting in your behalf request legal testimony or the disclosure of psychotherapy records. Under court order, I may be required to provide testimony. My fee for court testimony or depositions is 150% of my hourly fee. This fee is payable in advance and is required even if I am not called to testify.
- **Benefits and Risk of Therapy:** The success of therapy is partially dependent upon the depth of commitment of each individual client. The majority of individuals, couples, and families in therapy benefit from the process of counseling; however, no promises can be made in regards to the results of treatment or of any procedures provided by the therapist. Open, honest and accurate reporting of dilemmas and concerns are vital to progress in therapy. Self-exploration, insight, exploring options for dealing with problematic behaviors, learning new skills, or venting difficult feelings/experiences are generally very useful; nevertheless some risk does exist. Please understand that throughout the course of therapy some individuals experience unwanted feelings, and that examining old issues may produce unhappiness, anger, guilt or frustration. These feelings are difficult, but a natural part of the psychotherapeutic process and often provide the basis for change. Important decisions are often an outcome of counseling. These decisions, including changing behavior, exploring employment opportunities, substance abuse patterns, schooling, and relationships, are likely to produce new opportunities as well as unique challenges for each individual involved. Sometimes a decision that seems positive for one family member will be viewed quite negatively by another. Do not be hesitant to discuss counseling goals, procedures or your impressions of the services being provided with your therapist. If you ever do not understand a suggestion or comment that has been made, please ask for clarification.

CLIENT RIGHTS:

I, Debra M. Kraus, M.A., LMHC, am committed to providing service to you (the client) without regard to race, sex, age, religion, disability or sexual orientation. **As my client:**

You have the right to be treated in a respectful and confidential manner that maintains your individual dignity.

You have the right to nondiscriminatory services; to be provided services without regard to race, sex, ethnicity, age, sexual orientation, religion, AIDS/HIV status or disability.

You have the right to quality services suited to your specific needs, administered skillfully, safely, humanely with full respect for your dignity and personal integrity and in accordance with all statutory and regulatory requirements.

You have the right to be involved and to participate in the formulation and periodic review of your individualized service plan with your therapist. You have the right to ask questions, at any time, about what we do during therapy, and to receive answers that satisfy you.

You have the right to decide not to enter into therapy with me. If you wish, I will provide you with the names of other good therapists.

You have the right to express dissatisfaction with therapy and/or end therapy at any time. The only thing you will have to do is to pay for any psychotherapy treatments previously provided to you.

CLIENT CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT AND/OR PAYMENT

I have been provided the opportunity to review the "Notice of Patient Privacy Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "Notice" prior to acknowledging this consent.
- The right to restrict or revoke the use of disclosure of my health information.
- The right to request restrictions as to how my health information may be used to carry out treatment and/or payment

I understand that Debra M. Kraus, LMHC originates and maintains paper/and or electronic records which include assessment, diagnosis, symptoms, treatment plans, and if applicable, medication. I understand that this information serves as a basis for planning my care and treatment, is a means of communication among the health professionals who contribute to my care, and is required to process an insurance claim.

PLEASE CHECK ALL THAT APPLY

[ ] I authorize the release of any medical/other information necessary to obtain an authorization for treatment and/or process an insurance claim.
[ ] I authorize release of mental health/substance abuse information to my Primary Care Physician.
[ ] I authorize release of mental health/substance abuse information to the following persons: [ ] Spouse [ ] Parent (s) [ ]
Other:
_____

[ ] May contact by mail at home address. If you do not want to be contact at home by mail, please provide an alternate mailing address:
_____ _____

[ ] May contact at home telephone #.	[ ] at work #	[ ] at cell #	[ ] by email
[ ] May leave message at home telephone #.	[ ] at work #	[ ] at cell #	

My signature below shows that I understand and agree with all of these statements and have received a copy of this four-page form for my records.

_____ _____
Signature of Client (or person acting for client) **Date**

_____ _____
Printed Name **Relationship to client (if necessary)**

_____ _____
Debra M. Kraus, M.A., LMHC **Date**