**ROSALES COUNSELING SERVICES, LLC**
**Heather Rosales, LMSW, CAADC**
**808 West Lake Lansing Rd · East Lansing, MI 48823 · (419) 665-6366**
**heather@rosalescounseling.com**

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## DISCLOSURE STATEMENT AND CONSENT TO TREATMENT

**THERAPIST TRAINING AND CREDENTIALS:**
Thank you for choosing *Rosales Counseling Services, LLC* for your mental, emotional, and relational needs. I look forward to working with you in promoting personal growth, self-understanding, and relationship enrichment. I received a Master's degree in Social Work from Michigan State University following a Bachelor's degree in Human Services from Adrian College. I am a fully licensed Clinical Social Worker in the State of Michigan.

Therapeutically, I am trained to work with individuals, couples, and families. I tailor my services to meet each client's unique needs. I have significant experience working with children, adolescents, and adults in addressing a wide variety of issues. I do not provide emergency services; in the case of an emergency, you are advised to call 911 or go to the nearest emergency room/hospital.

**THERAPY SPECIFICS AND FEES:**
Therapy sessions last 45-60 minutes beginning on the ½ hour; they are typically held one to two times per week. Initial sessions are dedicated to assessment, which involves gathering information about you and the problem bringing you into therapy. To gain the full benefits of therapy, it is strongly encouraged that you fully participate in the sessions through regular attendance and a willingness to try alternative perspectives for both the problem and its solutions. Discussions regarding your case may be made in a supervisory process with other mental health practitioners with the intent to assist me in providing you the best care possible; any of your identifying information will remain confidential in supervisory processes. It is difficult to determine how many sessions will be necessary for an individual, couple, or family to make significant and long-lasting changes. However, it is recommended that you allow for at least eight sessions, followed by re-evaluation.

The client is responsible for the cost of each session. The initial assessment is billed at $200, while subsequent sessions are billed based on time, including the time required to clinically document the session: 45 minute sessions are billed at $150 and 60 minute sessions are billed at $185. Obligation for payment is understood not to be dependent upon the client receiving third party reimbursement, such as from health insurance coverage. While the clinician certainly supports and encourages clients to pursue the maximum amount of financial reimbursement from third party payers (i.e., health insurance agencies), it is ultimately the client's responsibility to ensure that s/he receives all third-party payments for which s/he may be eligible. I will submit claims to health insurance companies with whom I am an in-network provider or supervised provider. The client is responsible for all applicable co-payments and unmet deductible costs associated with his/her health insurance coverage. All applicable co-payments are due at the time of service.

Session fees cover the following professional services:
- ❑ Therapy for the individual, couple, or family system
- ❑ Initial and ongoing assessment
- ❑ Treatment planning
- ❑ Time spent in consultation with other professionals

Phone contact other than that used to schedule appointments is considered therapeutic consultation and is billed at a rate of $30 per 15 minutes. Report writing is billed at a rate of $150 per hour. There is a returned check fee of $20.

The client is responsible for engaging in and collaborating with the therapeutic process. As such, the client is responsible for attending the appointments s/he schedules. I require 24-hours advanced notice for cancelling and/or rescheduling appointments. If you fail to attend a scheduled appointment or cancel with less than 24-hours advanced notice, you will be billed $75. This is a strict policy with no exceptions. If there are repeated missed scheduled appointments or cancelled appointments with less than 24 hour notice, you may be terminated from services.

Please remember that if you are using health insurance, charges for phone consultation, report writing, and missed appointments will not be submitted for third party reimbursement and the client will be held responsible for those charges as specified above. It is practice policy to keep a valid credit card in each client's file; however, you may choose to pay an owed balance using an alternate form of payment. If a client has a due balance is due, payment is expected in order to continue scheduling.

**CLIENT RIGHTS AND LIMITS TO CONFIDENTIALITY:**
The client has the right to be given adequate information concerning the nature and course of their treatment, thereby allowing them to make informed, relevant decisions. Therapy is a voluntary act; thus, the client has the right to discontinue treatment at any time. However, it is ideal for the therapist and client to form a collaborative agreement concerning termination. Please note, the client can be terminated from therapy and referred elsewhere for reasons including: a.) excessive absences, b.) acting in a violent or hostile manner, c.) carrying a weapon in session, d.) attending a session intoxicated, and e.) failing to pay past-due fees.

The client has the right to expect total confidentiality, except as required by Michigan law and professional code of ethics wherein there is: a.) threat of serious harm to self or others, b.) reasonable suspicion of the abuse/neglect of a child or vulnerable adult, c.) court order, d.) voluntary release signed by client or guardian, and e.) in defense of a legal action.

**I have read and understand the information provided and I agree to the procedures and conditions therein. I understand that I may terminate therapy at any time and will be held financially responsible for any services already provided.**

Client Name (please print): _____

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

At times, there are persons who join the therapy process who are not identified as the "patient"; however, they are important to the treatment process. By signing below, you acknowledge this is a health care setting and that all aspects of therapy must remain confidential. Additionally, the protections in place through HIPAA policies protect you to the same degree as the primary patient. If a minor is joining the therapy process, the parent or legal guardian must consent that minor's participation by signing below.

Signature: _____ Date: _____

_____ **Initial here to acknowledge that you have read the Notice of Privacy Practices; a copy of the Notice will be provided to you upon your request.**

**INSURANCE CONSENT:**
By signing below, I give Heather Rosales, LMSW, CAADC permission to release all required information to my insurance company to attain payment for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

Signature: _____ Date: _____

**CELL PHONE CONSENT:**
Each client and/or guardian of the client is permitted to contact my cell phone, which includes voice calling and text messaging. My cell phone is to be primarily used for scheduling purposes and increasing efficiency of communication. Please note that if you call or text me, you may not receive an immediate reply; and, in some instances, I may defer concerns brought up via phone, voicemail, or text message until a scheduled therapy session. Please respect my typical business hours when calling or texting my cell phone. Providing this number in no way indicates 24-hour access to my services, nor should it be considered an emergency resource. If you are in crisis, you are still advised to call 911 or go to the nearest emergency room/hospital.

Permission to contact me via cell phone is a privilege that can be revoked if I deem that you – the client or guardian of the client – are abusing the privilege. This definition of abuse is to my discretion and includes, but is not limited to, repeated calls and texts despite my addressing the present question, comment, or concern.

HIPAA Privacy Disclosure: be advised that communication via cell phone is not entirely secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls or texts cannot be guaranteed. My cell phone will remain passcode protected and I will store your contact information using your initials rather than your name.

**By signing below, I understand and accept the conditions above.**

Signature: _____ Date: _____