Paulette Sears Counseling, LLC
927A S. 8th Street, Suite 300
Manitowoc, WI 54220

920-682-4804 www.paulettesearscounseling.com FAX: 920-684-1110

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. The relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

AVAILABLE SERVICES: Paulette Sears Counseling, LLC, offers a wide array of counseling services, including, individual, couples, family, child, and group counseling. Effective psychotherapy is founded on mutual understanding, respect, and good rapport between client and counselor. It is my intent to convey the policies and procedures used in my practice, and I will be pleased to discuss any concerns or questions you may have regarding your treatment.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there exist inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. However, the benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits include: improved personal relationships, reduced feelings of emotional distress, and specific problem solving. Although I cannot guarantee these benefits, it is my desire to work with you to attain your personal goals for counseling.

COUNSELING: I provide short-term counseling designed to address many of the issues clients are dealing with. Your first visit will be an assessment which together, you and I will determine your concerns and develop a plan of treatment.

The goal of counseling is provide you with the most effective therapeutic experience available to you. If at any time you feel that I am not a good fit for you, please feel free to bring this matter up with me, and we can discuss if transferring to a different therapist would be right for you. If we decide that other services would be more appropriate, I will be happy to assist you in locating a provider who can meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our emotional, physical, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. My services are designed to provide individuals an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Initially, appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions are available if it is determined appropriate to the individual's needs. Your scheduled appointment is expressly reserved for you, and as a courtesy I provide email or telephone reminders to you the day before your appointment. If you must cancel or reschedule your appointment, I require that you contact me at least 24 hours in advance so that your appointment time can be used by another client. Please note below the fee for failing to provide the required 24 hours advance cancellation notice.

FEE SCHEDULE:	Diagnostic and Evaluation Session (1st visit)	$ 170.00
	Regular Office Visit (50 min.)(Individual, Family or Couples)	$ 140.00
	Outside Office Work (court, collaborative legal services)	$ 140.00/hour
	Returned Check Fee	$ 35.00
	Fee for unattended session without 24 hours advance notice.	$ 40.00

PAYMENT/INSURANCE FILING: Payment of any required co-pays is expected at the time of each appointment, before your session begins. If you are using insurance, I will file insurance claims for you, and I will honor any contractual arrangements with managed health companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, full payment is expected at the time of service, and I will provide you with a statement of services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact me regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer you other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours, or on a weekend, my after-hours number will be given on my voice mail. You may utilize this number in the case of a serious crisis, and I will call you back as soon as possible. If you are experiencing a life-threatening emergency, call 911, or have someone accompany you to the nearest emergency room for help. When I am out of town, you will be advised and given the name and phone number of an on-call Therapist.

CONFIDENTIALITY: I follow all ethical standards prescribed by state law and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exception noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of elderly or disabled; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or credentialing board. If you have any questions regarding confidentiality, you should bring them to my attention and we can discuss this matter further. By signing this information and consent form, you are giving consent to this therapist, Paulette Sears, to share confidential information with all persons mandated by law and with the agency that referred you(when mandated to treatment

by that agency), and the insurance carrier responsible for providing your mental health services and payment for those services. You are also releasing and holding harmless this therapist, Paulette Sears, from any departure from your right of confidentiality that might result.

DUTY TO WARN/DUTY TO PROTECT: If my therapist, Paulette Sears, believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being. I hereby specifically give consent to my therapist, Paulette Sears, to contact the person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my therapist, Paulette Sears, to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate.

Name Telephone Number

_____ _____

_____ _____

INCAPACITY OR DEATH: I understand that, in the event of death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing This Client Information and Consent form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment, and services for me (or my child if said child is the client) and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, the therapist, Paulette Sears will not render services to your child until the she has received and reviewed a copy of the most recent applicable court order.

_____ _____

Signature—Client/Parent Date

_____ _____

Signature—Spouse/Partner/Parent Date

_____ _____

Therapist Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Client/Parent

I authorize the payment of medical benefits to the provider of services.

_____ _____

Client/Parent Date