CLIENT INFORMATION AND CONSENT

I. Therapist

The undersigned therapists are licensed professionals specializing in child, adolescent, and family counseling engaged in private practice providing mental health care services to clients directly. The undersigned therapists provide all mental health services through Michelle Morrison and Associates, LLC a limited liability company.

II. Mental Health Services

While it may not be easy to seek help from a mental health professional, it is hoped that you will be better able to understand your situation and feelings and move toward resolving your difficulties. The therapist, using her knowledge of human development and behavior, will make observations about situations as well as suggestions for new ways to approach them. It will be important for you to explore your own feelings and thoughts and to try new approaches in order for change to occur. You may bring other family members to a therapy session if you feel it would be helpful or if your therapist recommends this.

III. Appointments

Appointments can be made by calling Michelle Morrison at 410-203-9016 or by email michelle@morrisoncounseling.com. Monday through Friday between the hours of 9:00 A.M. and 5:00 P.M. Typically, it is expected that appointments be scheduled at least one week in advance. Please call to cancel or reschedule at least 24 hours in advance of the scheduled appointment.

IV. Number of Visits

The number of sessions needed depends on many factors and will be discussed by the therapist. Clients seeking reimbursements for the subject sessions should first confirm the number of allowable sessions covered by their insurance plan.

V. Length of Visits

Therapy sessions are 45-60 minutes in length and are considered a clinical hour. The group will begin at 4:30 p.m. and between 5:45 or 5:50, please be prompt in picking up your child at the close of the group.

VI. Relationship

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapists not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you, but is not in a position to be your friend or to have a social or personal relationship with you.

Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

VII. Cancellations

Please contact our offices to let us know if your child will be unable to attend one of the group sessions. There is no rebate or prorated fee for sessions for which your child is unable to attend. The success of the group and future groups are dependent on the presence of all group members.

VIII. Payment of Services

The intake appointment will be held with both the group participant and parent(s) and is not a guarantee that the child will be deemed appropriate for the group. The cost for the intake appointment is $170.00. The first group payment is due at the start of group. The second payment will be due at the mid point of the group course. Payment amounts are based on the number of group sessions. Your therapist will communicate the number of sessions and amounts at the intake appointment. There is no rebate or prorated fee for sessions missed. The undersigned therapist does not normally accept assignment of insurance benefits. The undersigned therapist will look to you for full payment of your account, and you will be responsible for payment of all charges due at the time of service. Telephone conversations lasting more than 15 minutes will then be considered consultations and will be billed.

If you have medical insurance that provides coverage for mental health counseling, we are anxious to help you receive your maximum allowable benefits. We do not accept assignment of benefits (get reimbursed from insurance companies), nor do we participate in managed care insurance plans (HMO's, PPO's, and other organized health networks).

We will be happy to assist you in the completion of your insurance claim form for reimbursement. A completed insurance claim form must accompany any such request at each visit. You are responsible for mailing your claim form and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our fees are generally considered below or within the acceptable range by most companies, called "Usual, Customary, and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "scheduled" of fees, which bares no relationship to the current standard and cost of care in this area. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to contact your company regarding the above to find out about their reimbursement policies.

Although, it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. Confidentiality and exceptions to confidentiality are discussed below. In the event law requires disclosure of your records or testimony, you will be responsible

for and shall pay the cost involved in producing for and giving testimony. Such payments are to be made at the time or prior to the time the therapist renders the services.

IX. Confidentiality

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 the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in 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 board. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing this information and a consent form, you are giving consent to the undersigned therapist to share confidential information with all persons mandated by law and your insurance carrier, if you should seek reimbursement, and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

X. Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

NAME TELEPHONE NUMBER

____

____

____

I consent for the undersigned therapist to communicate with me by mail and by phone at the following addresses and phone numbers, and I will immediately advise the therapist in the event of any change:

ADDRESS TELEPHONE NUMBER

____

____

XI. After-Hours Emergencies

A mental health professional or your therapist is on call when your therapist's office is closed, and can be reached for emergencies on a twenty-four-hour, seven-days-per-week basis, by calling 410-258-1172. Emergencies are urgent issues requiring immediate action.

XII. Therapist's Incapacity or Death

I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon my requests, or deliver them to a therapist of my choice.

XIII. Consent to Treatment

I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned therapists to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

________________________________ ____________________
Client/Parent Date

____
Social Security Number and Address

________________________________ ____________________
Client/Parent Date

____
Social Security Number and Address

As witnessed by:

__________________________________ ____________________