**JOYCE D SCHERDIN,** MSC
Licensed Marriage & Family Therapist
8011 LaGrange Road, Suite 8
Louisville, KY 40222
(502) 396-0087

# Informed Consent

Today's Date: _____/____/_____

**CLIENT INFORMATION:**

Name: _____

Date of Birth: ____/____/_____

Address:_____

_____Zip Code_____

Phone: _____

Secondary Phone:_____

Email: _____

How may I contact you? Check all that apply: Phone_____Text_____Email____Mail_____

Emergency contact (Name, Phone, Relation):

_____

_____

**CONSENT TO TREATMENT:** This agreement made this _____ day of _____, 20_____, by and between **Joyce D Scherdin,** (Therapist) and _____ (Client). Consent to treatment for myself, or for my family member who is a minor or dependent adult.

- The Therapist shall provide counseling as it pertains to the client(s) needs.
- All therapy will be within the scope of professional practice per the State of Kentucky Board of License for Marriage and Family Therapy.

- _____(signature)

**DISCLOSURE STATEMENT:** JD Scherdin, Inc., doing business as Scherdin Counseling is established to provide therapy to individuals, couples, married or pre or post-marriage, and families. I am a Licensed Marriage and Family Therapist with a Master's of Science in Counseling. As a Therapist I utilize approaches that are the best fit for each client(s) needs and goals. I understand that seeking counseling and participating in psychotherapy with a Therapist can be very helpful and can result in an improved life, improved circumstances and improved relationships, along with or in addition to reduced psychological symptoms. At times life, circumstances and relationships may appear to be or be experienced as deteriorating while in counseling. Often in the course of change this can occur naturally. As you think about a physical injury, the natural course of the body's process is to temporarily appear to be getting worse through signs of bruising, or increased irritation to the wound as examples, while the healing process progresses. Therapy progresses in much the same way, so I invite you to be patient with yourself, the current circumstances, and the counseling process as together we move toward the improvements you are seeking through therapy.

**CONFIDENTIALITITY:** I understand that all information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information.

State law dictates specific exceptions to maintaining confidentiality; Joyce D Scherdin, therapist is required by law to break client confidentiality when any of the following occurs:

- I am required to report abuse (including physical, sexual or neglect) of a minor, vulnerable adult or elder adult.
- I am required to report the use of controlled substances while pregnant.
- I am required to report the intention to seriously harm yourself or others.

- I am required to comply with state or federal law, rules or regulations to disclose information when Court ordered.

**POLICIES:**

**Telecommunication Policies:** I understand that if I need to contact my Therapist by phone, I should not hesitate to call her at (502) 396-0087. If you elect to communicate with your therapist via telephone, email, or other similar methods confidentiality cannot be guaranteed. Additionally, extended phone calls which serve as therapy sessions will be prorated hourly per our therapy service fees.

**Out of Session Emergency**

When you are not in session, your therapist may not be available due to other clients, unforeseen events or being outside normal business hours. You may leave a message on the confidential voicemail at 502-396-0087 and your therapist will return your call within 1 business day. If it is an emergency please call 911 or 800-221-0446 a crisis hotline.

**FINANCIAL AGREEMENT**

Joyce D Scherdin, is a fee for service provider. This means the service fee is the client's responsibility to pay at the time of service. There are many benefits to a fee for service provider. Your therapist is not required to diagnose you with a mental disorder in order to be reimbursed or reported to the Medical Information Bureau. Your privacy is maximized. You, the client have control over what care you receive and for how long.

I _____, agree to pay $145 for a 50 minute session. I understand that the fee is billed if session is cancelled less than 48 hours in advance. I agree to a $25 service charge for any returned checks on my account. I understand that I am responsible for all fees at the time the service is rendered, and agree to a loss of confidentiality for the purpose of collecting fees in court if I incur an outstanding balance more than six months after my last session.

**Appointments:** *Cancellation of an appointment without a minimum 48 hour notice will result in the full appointment fee charged to the client*. _____(initial).
If 3 or more sessions are missed without giving 48 hour notice, therapist, Joyce D Scherdin reserves the right to end therapy services by letter/phone.

In the event, for any reason, the insurance company denies payment for a service provided, I agree to pay in full the cost of services provided to me by the therapist, Joyce D scherdin.
_____ (client).

**Legal and Court related Policy**

Clients are discouraged from having their therapist subpoenaed. Even though you are responsible for the testimony fee, it does not mean that my testimony will be solely in your favor. I can only testify to the facts of the case and to my professional opinion. For those who fail to heed this discouragement, the following fees are in effect:

1. Preparation time (including submission of records): $220/hr
2. Phone calls: $220/hr
3. Depositions: $250/hour
4. Time required in giving testimony: $250/hour
5. Mileage: $0.40/mile
6. Time away from office due to depositions or testimony: $220/hour
7. All attorney fees and costs incurred by the therapist as a result of the legal action.
8. Filing a document with the court: $100
9. The minimum charge for a court appearance: $1500

A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 “express” charge. Also, if the case is reset with less than 72 business hours’ notice, then the client will be charged $500 (in addition to the retainer of $1500).

***Credit Card Policy for No Show Fees & late cancellation (Required for Therapy)*** Enter your credit card number_____ _____ _____ _____ Security code_____, Expiration Date_____ and billing zip code_____ for this card. Please bring Card to 1st Session to Confirm. You will not be charged on this card unless you cancel your appointment with less than 48 hours' notice or a No Show appointment incurred.

*I have read all of the above and every preceding page of the client informed consent and understand its contents. My signature below shows that I understand and agree with all of these provisions set forth above and in the preceding pages of the client informed consent.*

_____ _____ _____

Signature of client (or client legal guardian) Printed Name Date

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## CLIENT DATA FORM

This confidential information data form should be completed for each individual who will be attending counseling. Complete this form carefully and completely. Use the back for any additional information.

### GENERAL INFORMATION

Name_____

Date of Birth_____

Phone_____

Phone _____

Address _____

Emergency Contact Information:

(Name, Phone & Relation) _____

Your Occupation_____

Place of Employment_____

Highest Level of Education _____Degree_____

Gender M F Race/Ethnic _____

Country of Origin_____

Social Security No _____

Military History_____

Relationship Status (circle one) Single Dating Engaged Married Separated Divorced Widowed

Length of Time _____ Number of Marriages _____

Referral Source_____

**Health Information**

Primary Physician (Name & Phone number)_____

_____Date of last visit_____

List Medications & dose_____

Recent weight changes _____

Describe your current physical health_____

Have you seen a psychiatrist before? Yes____No____ When_____

Please list any significant issues with sleep, food, drugs, alcohol, and medication

_____

_____

Hospitalizations (When/Why)_____

**Spiritual Information**

Supportive Faith Beliefs _____

Faith affiliation_____

Current involvement_____

Do you believe in God? Yes____No____ Uncertain_____Unimportant_____

Significant changes in your spiritual experience?_____

How your Spiritual situation impacts your need for therapy?

_____

_____

**Relationship Information**

Spouse's Name_____Phone_____

Address (if different from yours)_____

City_____State_____Zip Code_____

Place of Employment_____Occupation_____

Gender M F Date of Birth_____Age_____Nationality_____

Spouse's Education Level_____

Date of Marriage_____Where_____

How old were you both when you married? Husband_____Wife_____

Previous marriage(s)? How did they end? Dates of marriage?

_____

_____

List children from the marriage(s). Use the last page for additional information or as needed.

Name(s) of children Age Sex Living/Deceased Marital Status

_____

_____

_____

List your current household composition_____

_____

Name of Significant person you are in a committed Relationship_____

How long have you known this person_____?

How long have you been committed to this person_____?

Name(s) of children, Age, Sex, Currently live with you?

_____

_____

_____

Are your parents living? Yes___No___ If no, when and how?_____

Were you raised by someone other than biological parent(s)? Yes_____No_____

If yes please explain_____

Are your parents married? If no when did the marriage end and how_____

Do you have a step parent(s)?_____

Describe your parents' relationship_____

_____

Describe your childhood _____

_____

_____

List siblings in birth order (include yourself)

Name Sex Age Living/Deceased Marital Status Children

_____

_____

_____

_____

_____

## Counseling Needs

What are your concerns that bring you into counseling?_____

_____

List any symptoms you are experiencing that are related to these concerns_____

_____

What do you hope to change as a result of our counseling work?_____

_____

Please use the remaining space to communicate additional information not covered in this form.

_____

_____

_____

_____