

JOYCE D SCHERDIN, MSC

Licensed Marriage & Family Therapist

8011 LaGrange Road, Suite 2

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 _____

Relationship _____

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 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.

CONFIDENTIALITY: 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.

Joyce D. Scherdin, MSC, Licensed Marriage & Family Therapist

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.

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