Jude LaClaire, Ph.D., LCPC, LCSW
5453 W. 61st Place
Mission, KS 66205
913-322-5622

Informed Consent for Psychotherapy

New Client

Thank you for choosing me as your psychotherapist. I am taking this opportunity to acquaint you with information relevant to your therapy, confidentiality and office policies. Please feel free to ask me any questions you may have regarding any of this information.

About Counseling

There can be many goals for the counseling relationship. Some are more immediate short-term goals and some are about the quality of your life and long-term goals. You will set these goals, determining what you want to work on in counseling. Some of these may be

1. Decreasing anxiety and depression
2. Changing behavior or dealing with addictions
3. Developing healthier relationships
4. Reducing stress, negative emotions and pain
5. Releasing traumatic memories
6. Learning to self-calm
7. Learn more about yourself; increasing personal awareness of strengths and resources
8. Explore your inner world through dream and multisensory imagery

Appointments, Fees and Insurance

Appointments can be made by calling Dr. Jude LaClaire at 913-322-5622 or 816-509-9277. Calls will be returned within 24 hours, Monday-Friday during regular office hours, excluding times when Dr. LaClaire's voice message indicates she is out of the office.

1. Fees: Individual/Couple/Family – 60 minute sessions: $120
   Sessions more than one hour are billable at the hourly rate. Phone conversations over 5 minutes will be billed at this rate.
2. When an appointment is made, you are responsible for that appointment date. No reminder calls will be made to you.
3. If you are unable to make a scheduled appointment time, you must cancel 24 hours in advance or a $70 fee will be charged. Appointments for 4:00pm or later will be charged $80.00. You will not be charged if we agree there is a true emergency.
4. If you need to change an appointment, please call to cancel and re-schedule. You may call 913-322-5622 or call/text Dr. LaClaire's cell phone, 816-509-9277 or email jude@kcholistic.com.
5. In the event of an emergency please call 911, your psychiatrist or primary care physician, or the local emergency room.
6. Dr. LaClaire is not listed in any managed care groups and does not have any direct contracts with insurance providers. For PPO and other group plans, you may be covered under "out of network provision.' Many plans cover from 50%-100% of the billed amount. Call your insurance's provider's Mental Health Service and ask how a mental health claim is made. Fees may be paid from Health or Medical Savings Accounts. Checks, credit cards and cash are accepted.
7. You will be provided with a statement including the necessary information for the insurance providers and a HFCA form, a general statement accepted by most insurance companies. If clinical updates are needed for re-authorization, Dr. LaClaire will provide that service.
8. You understand that a mental health diagnosis must be made for insurance claims.
9. Payment is to be made in full at time of service. For insurance claims, reimbursement is made to the client from 3rd party payer.

Contact Agreement

Let me know if you wish to communicate through email, text, cell phone, home or work phone.
I give permission for and wish to be contacted by:

Yes No

___ ___ Call and leave VM message #_____

___ ___ Call or Text message # _____

___ ___ Email _____

I understand that phone, text messaging and email are not protected modes of communication and confidentiality is not guaranteed. I give my permission with that knowledge.

Confidentiality

Issues discussed in therapy are confidential and are legally protected as privileged information. Here are some limitations to confidentiality:

1. Suspected abuse or neglect of a child, elderly or disabled person.
2. When I believe that you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, I must inform that person as well as the authorities.
4. You have signed a release of information for other parties to be contacted or to share information.

Record Keeping

A clinical chart of dates and fees for sessions is maintained. If your records are requested a diagnosis, dates of service and treatment summary will be released only with your written request.

Complaints

Please let me know if you have any complaints, concerns or questions as soon as possible**.** I would always be open to discussion of these issues. If you do not feel your complaint has been resolved you may inform the Board of Behavioral Sciences to file a complaint.

Consent for Treatment of Minors

I/we_____consent that _____
may be treated as a client by Dr. Jude LaClaire.

Treatment Agreement

You are responsible for your health and wellness. I am here as a facilitator, offering tools and skills in a safe space; encouraging, supporting, guiding you in your journey of healing and wholeness. You have an active role in setting goals, practicing behaviors between sessions, using your personal and community resources and giving feedback on progress. I welcome your feedback in assisting you in this task of growing and learning.

Consent for Counseling

Your signature below indicates you have read this agreement and agree to its terms.

Name (Please print)_____

Client Signature_____Date_____

Therapist Signatre_____Date_____