STONE CITY COUNSELING, Inc.

2325 Q Street
Bedford, IN 47421
Phone (812) 279-HOPE (4673)
Fax (812) 279-4672

Informed Consent for Treatment

I, _____, voluntarily consent to receive counseling services from Stone City Counseling, Inc's mental health providers (**Sharon Adams**, MSW, LCSW; **Mindi Robinson**, MSW, LCSW; **Wanda Harper**, MS Ed., CADAC II, LCAC; **Blake Keithley** MS Eds., LMHC; **Marie Dunlap**, MSW; **Brian Smith**, LMHC; **Marsha R. McCarty**, PHd., HSPP) as defined in Indiana law, for problems associated with emotional behavioral addiction/substance abuse or other mental health issues.

I understand the services offered will consist of an interview process to assess the nature of the problem(s) and ongoing counseling to help resolve personal aspects of mental health issues. In some instances a referral will be made to a psychiatrist to evaluate the need for medication or review current medications or to other mental health providers of expertise/settings. Such process of referral will be reviewed between client and therapist and determined if appropriate and agreeable. I understand that I am consenting only to those mental health services that these providers are qualified to provide within.

A. The scope of provider's license, certification and training in mental health.
B. The scope of license, certification and training of those mental health providers directly supervising the services received by the patient.

Please be aware of the following as a client consenting to treatment:

1. I will be given a clear description from my mental health provider regarding the problem, diagnosis , strengths limitations and treatment plan proposed. I will engage in developing goals and the treatment plan.
2. I will be given a clear recommendation for the types of treatment recommended be that individual/family/group /couples/addictions counseling/ psychiatric referral or a combination of services. Dates, times and sessions will be disclosed and discussed with provider
3. I voluntarily agree to undergo mental health treatment and understand that I may end treatment at any time. I understand that my provider may want to discuss this with me, but that I reserve the right to stop treatment. In the cases of minors, please see minor consent for treatment- "Consent to mental Health Treatment for Minors". Furthermore I understand that my mental health provider may make diagnostic and treatment recommendations with which I do not agree
4. I understand that my mental health provider cannot guarantee results. They however will clearly help me derive at goals and objectives and discuss continuation and discontinuation of mental health treatment.
5. I understand that there may be risks in participating in mental health services. These may include, but are not limited to, addressing painful emotional experiences or inconveniences due to costs/fees for services. I am aware that I can discuss any unforeseen risks vs. benefits with my provider at any time.
6. I understand that in the case of an emergency Stone City Counseling, INC does not have a 24 hour emergency hotline and any calls made after office hours or in the event for which a clinician cannot be reached all clients are referred to the local emergency room immediately. I understand that in Lawrence County there are currently two emergency rooms, one located at IU Health and one located at St. Vincent Dunn Hospital. If immediately going to the emergency room is not an option either both or at minimum Stone City Counseling, INC recommends dialing 911 and asking for help.
7. I understand that if I have a grievance I am to try and speak with my provider. If this is not satisfactory or the grievance is against the provider I will utilize the information located in policy and procedure of Stone City Counseling, INC for making contact with the CEO Mindi Robinson, LCSW or her delegated staff.
8. I have the right to discuss my bill, payments and insurance information with the provider assistants in the billing office. While insurance is filed as a courtesy I understand that it is not a guarantee for/of payment.

By signing this form I understand and agree to the contents that have been outlined in this consent form; and that if I request, I may have the contents orally explained to me and receive a copy of this agreement.

Client Print Name: _____

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____