

7305 Baltimore Avenue, Suite 307

College Park, MD 20740

240-582-7513

301-979-7504

[panderson@pace-consulting.com](mailto:panderson@pace-consulting.com)

www.pace-consulting.com

**Informed Consent for Therapy Services**

Thank you for engaging in counseling. This document contains important information about our professional counseling services and the business policies of PACE Consulting, LLC.

**COUNSELING SERVICES**  
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 1-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what that work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about the procedures, you and your therapist should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

**Policy of Non-Discrimination and Referrals**

PACE Consulting does not discriminate on the basis of a client’s race or ethnicity, sex, gender identity, sexual orientation, religion, age, or disability. If a counseling issue arises that is out of the therapist’s expertise, a referral will be given to another therapist to continue services. The Prince George’s County Crisis Center is available 24-7 to Prince George’s County Residents for emergencies. Their number is 301-429-2185 and the the administrative office is located in Lanham, MD.

**INFORMED CONSENT AND RELEASE OF INFORMATION**

All information obtained/derived by the course of treatment is fully confidential; disclosures you share with your therapist are confidential unless you have SIGNED a consent form to release part or all the information. Therefore, to either release or obtain information from a specific individual or agency, a Release of Information must be obtained. Exceptions to this guideline include instances when 1) the patient is a clear danger to (a) themselves or (b) others and, 2) instances when the patient is a minor (under the age of 18) and reports that he or she is or has been a victim of physical, emotional or sexual abuse. Please sign and date all Release of Information documents. 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 disclosure of your records or testimony is required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate for time involved in preparing for and giving testimony. Such payments are to be made at the time or prior to the time the therapist renders the services. Your signature on this form will allow this process to proceed smoothly.

**Confidentiality, Privilege and Privacy**

Conversations and issues discussed in therapy sessions are private and protected ethically and legally, except for the following instances:

* Client signs a release of information authorizing sharing of information
* Counselor is a mandated reporter and must notify authorities in suspected cases of physical, mental or sexual abuse of minor children
* Counselor is a mandated reporter and must notify authorities in suspected cases of physical, mental or sexual abuse of vulnerable adults
* Counselor may be required to report credible threats or intent to inflict injury on self or others or take other action to eliminate the possibility of harm
* Counselor is under court order or, in certain circumstances, under subpoena to produce protected health information or testify
* Where any other information is required by law to disclose
* Counselor reserves the right to not participate in any future divorce and custody proceedings, save for mandated reporting of abuse as stated above

Your counselor will not engage in a personal virtual relationship or communicate with you on any personal social media interface, adhering to the 2014 Code of Ethics of the American Counseling Association.

Your counselor must complete continuing education classes and may engage in case consultation or supervision with other professionals when needed. Client names and identifying information will with be withheld when discussing any case concerns with other professionals.

Your counselor may see you in a public setting, (such as a grocery store or school) and to protect your confidentiality, your counselor will not acknowledge you or initiate a greeting. This is not meant to be rude, but to protect your privacy. If you greet your counselor first, your counselor will respond politely and move on. Please do not confirm appointments or discuss anything related to counseling in a public setting.

Please be aware that others may overhear any conversation outside of the closed office door. To protect your privacy, please refrain from speaking of private matters in the waiting room or outside of the office.

Electronic communications, including text messages and emails are part of your file. Emails sent from non-encrypted sources, including work computers, are not necessarily secure.

If understand that if I choose to use e-mail or send text messages, I am aware that it may not be secure. Therefore, I agree to use email or text messaging only for making/changing appointments or other brief, non-sensitive communications.

[ ] I have read and understand the limits of confidentiality, privilege and privacy:

(Printed Name of Client):

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Printed Name of Parent(s) or Guardian(s) if minor:

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**Research and Development**

Your counselor may be involved in future research and development. Such endeavors usually include audio or video recordings of sessions as well as case presentations to other professionals. Your name and any identifying information will not be used. **You are not required to participate in any research and declining to participate will not impact counseling services**. Please check and sign below one of the following:

[ ] I agree to participate in research or supervision that would entail:

[ ]audio only [ ]video recordings only [ ] audio and video of my counseling sessions.

I understand that my identity will be kept confidential and any recordings of my sessions will not become part of my medical file. I understand I can retract my authorization at any time with written notice.

[ ] I do not agree to participate. I know this decision will not influence care or continued services.

(Printed Name of Client)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Termination of Services**

You have the right to discontinue or terminate counseling services at any time. There is an inherent risk of relapse and harm if you withdraw from counseling services prior to completing therapy treatments. If you miss two consecutive appointments, are non-compliant with treatment, or are no longer making progress towards treatment, you will be discharged from this practice.

If your counselor is incapacitated or unavailable for continuing care, another mental health professional will be made available to you. Recommendations for continuing care or referrals to another provider will be provided to you upon discharge.

**In Case of Emergency**

Sometimes, during therapy, symptoms may get worse before getting better. If you feel you are getting worse, please call your therapist’s cell phone first to check in and schedule an urgent appointment. **Note:** Generally, our therapist’s do not answer the phone after 9pm, as it is turned off for the evening. Your therapist will do their best to return phone messages within 24 hours.

If you cannot wait for my return call, or you are in crisis, please call the Prince George’s County Crisis Center, 240-777-4000, available 24-7 to Prince George’s County residents. Do not hesitate to call 911 or go to the nearest Emergency Room. If your counselor will be away for an extended period, options will be made available to you for urgent matters until your counselor returns.

I have read and understand what to do in case of an emergency:

(Printed Name of Client)

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**Payment for Services**

PACE Consulting is a provider for Maryland Medicaid, Optum Healthcare, Carefirst, and various EAP (Employee Assistance Programs) companies. PACE is considered out of network for other plans and insurance companies at this time. You may be eligible for out of network benefits from your insurance company, please contact your insurance company directly to clarify your out of network benefits.

Your therapist will give you a receipt for services to submit to your insurance company for out of network reimbursement. Minimal information will be shared with your insurance company for reimbursement purposes, including diagnosis and dates of service.

Your 45-50-minute session will cost $\_\_\_\_\_\_\_\_\_\_\_ as a copay and fees are due to your therapist at the beginning of the session. Acceptable payments are Visa/Mastercard, cash, and checks made payable to PACE Consulting, LLC. \_\_\_\_ authorized sessions through your Employee Assistance Program (EAP) are free.

Sessions cancelled with less than 24-hour’s notice are subject to a ***missed session fee of $50,*** which is not reimbursable by insurance companies. **Note**: This fee does not apply to those covered by Medicaid insurance.

**Three consecutive missed sessions will result in termination of services.**

All returned checks are charged a returned check fee of $30.00. Any returned checks will result in forfeiture of accepting future check payments and only cash or charge cards will be accepted.

If you request that your therapist attend a meeting outside of the office (for example, school conference, IEP meeting) there will be a charge equivalent to the time spent, including travel time at the same hourly rate of your sessions. **Note**: This additional fee does not apply to clients with Medicaid insurance.

Outstanding balances over 45 days may be subject to collection services and fees in addition to the original costs.

[ ] I agree to keep my Visa/MasterCard on file for payment of copays and other fees and may opt out at any time with written notice.

(Printed Name of Client)

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**Complaints**

If you have a complaint about counseling services, please feel free to discuss with me. If that does not solve the issue, you have the right to make a report to the Maryland State licensure board:

Maryland Board of Professional Counselors

4201 Patterson Avenue

Baltimore, MD 21215-2299

Phone: 410-764-4732

Fax: 410-358-1610

[www.dhmh.maryland.gov](http://www.dhmh.maryland.gov)

**Consent to Treatment**

[ ] I was offered a copy of this informed consent form.

I have read and understand the policies contained herein and I agree to treatment for:

(Printed Name of Client)

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Therapist/PACE Consulting, LLC