Transitions
Counseling and Consulting

Informed Consent

Name:_____Date:_____

Address:_____

Phone (Home)_____Cell_____Date of Birth_____ SSN_____

Occupation_____Employer_____Work phone_____

Spouse's name/Minor child's parents name_____Work phone_____

Primary care physician_____Please list current medications_____

Have you had previous therapy?_____ With whom?_____

In case of emergency contact:_____ Phone_____Relationship_____

Whom may I thank for referring you?_____

Fees: The fee is $250 for the initial assessment. The fee is $150 for 50 minutes of counseling sessions. Transitions Counseling offers a sliding scale for those who may not be able to afford to pay. Fees will be remitted at the end of each session. Checks should be made out to Meagan Foxx.

Cancellation: Please give at least 24 hours notice when canceling an appointment. Failure to do so will result in a $65 charge.

Guarantee: There is no guarantee in therapy. You may experience more emotional pain while working on deep issues. The therapy work is intended to increase insight and improve quality of life. All issues will be met with utmost care, respect and honesty.

Confidentiality: All the work done in the consultation room and within the therapeutic relationship is confidential. Who you are, what you say, and what you do will be held in the strictest confidence and the greatest respect with the following exceptions:

- Intent to harm self or intent to harm others: I am mandated by federal and state regulations. If you state the intention to harm a reasonably identifiable victim, this would be reported to that person and their local police. If you had a serious plan to harm or kill yourself, confidentiality may be broken in order to ensure your safety.
- Child abuse: If there is a report of any ongoing physical, sexual, emotional abuse or neglect for a child, there will be a report made to Child Protective Services in the child's local area.
- Dependent/Elder abuse: If there were a report of dependent adult or elder abuse, this would be reported the Adult Protective Services in that person's local area.
- Collections: If payment was not made for three months or more, and no other arrangements have been made, your name may be given to a collections agency to attempt remittance.
- A signed letter of release of confidentiality.

- A court of law may subpoena records.
- I may discuss our work together with another therapist or colleague to get supervision. If this occurs, your identity will be disguised.
- NOTE: Before any of these reports would be made, you would be made aware if at all possible.

Termination: You have the right to terminate treatment at any time. It is recommended that there be at least one session prior to termination for closure. I may terminate treatment with you if payment is not made, if progress has not been made in therapy, if it is in the best interest of your continued treatment, or if there is a refusal to follow therapeutic recommendations (such as remaining sober, filling prescriptions etc.). At this time, you would be given access to three recommendations for continued care.

Accessibility: If time and attention is needed between sessions, please leave a message on my answering machine and I will get back to you within 24 hours. If there is an emergency, please call me on my cell phone at (602) 363-0629. I will get back to you A.S.A.P. If a more severe emergency occurs, please call 911.

I the undersigned authorize and consent to treatment with Meagan Foxx, LPC, LISAC. I have read this consent form and agree to all it entails.

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature of therapist Date

_____ _____
Signature of parent or guardian Date

_____ _____
Signature of parent or guardian Date