Richard Brousell, MFT, MAC, LPCMH
2505 Foulk Woods Road
Wilmington, DE. 19810
302-475-6077
Fax 302-475-1641

INFORMED CONSENT FOR TREATMENT

By my signature below, I give my informed consent to participate in behavioral health care services with Richard Brousell, LPCMH under the following guidelines:

1. Information revealed in the course of the therapeutic process is held within standards of confidentiality described in state and federal law and can only be released to a third party with the expressed written consent of the patient (over the age of twelve) with the following provisions understood for unauthorized release:

   A. Threat of imminent harm to self or others.
   B. Threat by the patient of harm against a specific person.
   C. Child or elder abuse.
   D. Information requested by your insurance company should you choose to use your health insurance to cover the cost of therapy.
   E. Information released by written consent to a third party, such as an insurer, is not protected.

2. I consent to services for which this therapist is qualified to provide by training, certification and licensure in the state of Delaware (license# 0000124, LPCMH). Treatment shall meet practice standards for professional counseling.

3. Information shared in couples and/or family counseling is confidential relative to persons outside the couple or family but not between/among members of the couple or family.

4. Sessions are billed at $140.00 per 60 minute session unless otherwise established by special arrangement with the therapist. Sessions scheduled after 4 PM Monday through Friday or any sessions scheduled for Saturday will be charged at a rate of $165.00 per 60 minute session. **Lower fees can be negotiated with the therapist based on legitimate financial hardship.** Insurance may cover part of the cost based on your specific plan. Payment is expected at time of service. The patient is ultimately responsible for any balance due for services rendered. You may be charged for extended phone calls, report preparation or other services that require more than fifteen minutes of non- session time and are not covered by insurance. Please note there is a cancellation charge for the full session fee unless cancellations are made 48 hrs (business hours) in advance.

5 Requests for records should be made in writing to the therapist one week prior to the date needed. The cost of the records will be charged on a one dollar per page basis.

6. Any matters of concern about the actual therapy should be directed to the therapist so that satisfactory adjustments can be made or a mutual decision reached to terminate treatment. Should you wish to express a grievance regarding ethical or clinical misconduct patients may contact the licensing board for professional counselors of the State of Delaware to discuss and/or report any matters of concern.

7. The patient may terminate treatment at any time without explanation. Any balance due continues to be the responsibility of the patient or parent/guardian.

8. Therapy is a process intended to promote positive change for the individual and/or family. In the course of therapy emotionally difficult conflicts, thoughts and/or memories may emerge and should be understood as a normal part of the therapeutic process. Complete honesty is mandatory. Dishonesty during the course of therapy is considered treatment non-compliance and may result in termination of services.

9. Urgent calls can be made to the therapist at any time. Life threatening emergencies should be managed with the help of 911 services or at the nearest hospital emergency department.

10. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment or that I am legally authorized to initiate and consent to treatment on behalf of this individual through power of attorney.

11. Payment is required at time of service. Checks may be accepted for payment with prior agreement with the therapist. All patients shall provide a valid credit card/debit/medical savings card as a guarantee for payment of fees even if paying in cash. Account balances may be maintained by prior arrangement. My signature below authorizes the office to charge my card for any charges incurred.

12. Audio or video recording of part or all of the session(s) is strictly prohibited without prior written agreement. The use of electronic devices during sessions is highly discouraged and permissible only under very special circumstances which would require agreement by all parties involved.

_____ _____

Patient Parent/guardian

_____

Patient

_____ _____

Witness date

PAYMENT GUARRANTEE DATA FORM

Name on Card_____

Card Type (circle one) Visa MasterCard Discover Amex

Card #_____

Expiration Date_____

Three digit security code (on back of card) _____

Street#_____

Zip Code_____

PLEASE NOTE: Information provided above will be used to charge fees associated with therapy appointments. Cancellations or schedule change requests can be made by telephone to 302-475-6077 or 302-559-4248 (cell phone using voice or text), or email to rpbrousell@verizon.net. **Please provide 48 business hours notice of any changes to a scheduled appointment.** Appointments missed due to sudden, acute and verifiable situations (e.g. illness, accident, death in family**) will not be billed**. If the therapist's schedule has openings that allow for the appointment to be rescheduled within the week of the appointment, the missed appointment **will also not be billed. All payment information is kept in a locked, secure location along with all other patient information. The credit card system is also encrypted to insure your security.**

_____

Signature as it appears on your card

_____

Date