Vita Serenity Counseling, LLC || 855 E. Brandon Blvd, Brandon, FL 33511|| 813-650-6497

NAME: _____ DOB: _____

INFORMED CONSENT: Thank you for choosing Vita Serenity Counseling, LLC. for your counseling needs. Your initial appointment will take approximately 60-80 minutes and subsequent sessions will be approximately 30-45 minutes. Realizing that starting counseling is a major decision and you may have many questions, this document is intended to inform you of our policies, State and Federal Laws as well as your rights. If you have other questions or concerns, please feel free to ask your therapist.

Treatment practices, philosophy and care plan limitations as well as risks will be discussed with you during your initial visit.

CONSENT FOR TREATMENT FOR ADULT: By signing below, I _____ (client) am acknowledging approval of services and am consenting for therapy services provided by Mildred Dominguez, MA, LMHC at Vita Serenity Counseling, LLC. I further acknowledge that I have read this policy, general information, and the informed consent agreement.
***Please Initial: _____**

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We the parent(s) or guardian(s) of _____ (child/client), give consent and approval for Dominguez, MA, LMHC of Vita Serenity Counseling, LLC to work with my/our child in therapy. I/We understand that the therapy sessions with my/our child are confidential, but that I/we will be involved with the treatment process as needed at the request of the therapist. By signing below, I/we are stating approval of services and that I/we are consenting for treatment (for my child and/or myself) and I have read this policy, general information, and the informed consent agreement.

***Please Initial: _____**

CONFIDENTIALITY: Vita Serenity Counseling, LLC is required to keep timely records of therapy and maintain confidentiality of all records. Your verbal communication and clinical records are strictly confidential except for information (diagnosis and dates of service) shared with your insurance company to process your claims, when information necessary for case supervision or consultation, and/or when required by law.
All information disclosed within sessions and the written records pertaining to those sessions and communication between client, parent/guardian, and therapist are confidential and may not be revealed to anyone without appropriate written permission by the client, except where required by law. If the client is under the age of 18, the approval of the client and the parent/guardian are required, except where required by law.

In the event that the therapist is incapable of continuing therapy services due to illness or death, files will be accessed by a designated therapist who will keep the confidentiality of those files as expected and continue services if jointly agreed upon. Client files are kept for 7 years. If the client is a minor, the

records will be kept for 7 years after the client turns 18 years of age.

***Please Initial: _____**

WHEN LAW REQUIRES DISCLOSURE: The State of Florida requires that Vita Serenity Counseling, LLC. inform you that under the following circumstances, confidentiality will be breached:
1. When there is cause to suspect a child, adolescent, or elder has been or may be abused or neglected.
2. When there is reasonable cause to believe that someone poses risk of imminent harm to themselves.
3. When there is reasonable cause to believe that someone poses risk of imminent harm to another individual.
4. When there is a valid court order compelling records or witness testimony.

***Please Initial: _____**

LITIGATION LIMITATION: Due to the nature of the therapeutic process and the fact that it involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as but not limited to, divorce and parenting disputes, injuries, lawsuits, etc.) neither you (client), parent/guardian, nor your attorney, nor anyone else acting on your behalf will call upon Mildred Dominguez, MA, LMHC to testify in court or any other proceeding, nor will a disclosure of the psychotherapy records be requested. If a parent or guardian is bringing his/her child to Vita Serenity Counseling, LLC. to help during a stressful time such as court cases in the family's life, then the representative of Vita Serenity Counseling, LLC. work is directed toward helping the child in therapy. Therefore, the above-mentioned representatives will not participate in court proceedings because it is counterproductive to the therapy process. By establishing this policy from the beginning, each person's rights are being protected as well as keeping the therapy room safe and confidential. In some situations, and at the therapist's discretion, the therapist may agree to write a report about the client's progress in therapy. If the client is a minor, then both parents will receive a copy of the report. Please remember that, as stated above, Mildred Dominguez, MA, LMHC is a mandated reporter and if your child was to report abuse the counselor is bound to report it to the Department of Children and Families.

***Please Initial: _____**

YOUR RIGHTS: As a client, you have the right to terminate treatment at any time and request appropriate referrals from Vita Serenity Counseling, LLC. If at any time you want another professional's opinion or wish to consult with another therapist, your current therapist will assist you in finding someone qualified. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances where your therapist at Vita Serenity Counseling, LLC assesses that the release of such information may be harmful in any way. In such a case, your therapist will provide the records to an appropriate and legitimate mental health professional of your choice.

***Please Initial: _____**

TERMINATION: During the first couple of sessions, your therapist will be assessing if they can be of benefit to you. If following the assessment, the therapist feels that another provider will be a more appropriate match, you will be given a number of referrals for you to contact that specialize in your area of concern. If at any point during therapy, your therapist assesses that they are not effective in helping

you reach your therapeutic goals, they are obligated to discuss it with you and if appropriate, to terminate treatment and refer you elsewhere for more appropriate treatment. If you request it and authorize it in writing, your Vita Serenity Counseling, LLC therapist will speak with the referred therapist of your choice to assist with the transition process. You have the right to terminate therapy services at any time.

***Please Initial: _____**

FINANCIAL/INSURANCE ISSUES: The full fee of service is due at each session. Cash or Credit Card are the only approved payment methods at this time. The initial session will be approximately 60-80 minutes and you will be charged $120. Each additional session will be approximately 45 minutes in length and you will be charged $95/session depending on the scheduled session. If you are experiencing financial difficulties, consideration for a sliding fee can be discussed with your therapist at your initial appointment and accompanying financial documents will be required of you.
(i.e. 4 weeks of proof of wages).

Documentation/FMLA/Consultations: Fees may also be charged on a pro-rated basis for other professional activities necessary for good clinical care or for professional services you may request of me. These include time spent writing letters or reports on your behalf; telephone consultations initiated by you or family members, or with other professionals on your behalf, treatment summaries necessary for referrals, FMLA paperwork, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. or insurance disability paperwork. The cost for this time is $95/ hour
***Please initial: _____**

If you are receiving assistance from any other source to pay for your sessions, please be aware that you are ultimately responsible for any charges accrued. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. Please notify your therapist if any problem arises during the course of therapy regarding your ability to make timely payments. ***You may have a copy of this form, if requested.**

***Please Initial: _____**

APPOINTMENTS & CANCELLATIONS: Appointments are reserved specifically for you; therefore a 24-hour cancellation notice is required if you are unable to attend a previously scheduled appointment. **If for any reason you fail to give 24-hour notice of appointment cancellation, you will be billed in full for the missed session. Until the charge has been paid, you will not be able to schedule any future appointments. If you cancel within the 24 hours prior to your appointment or fail to attend two consecutive appointments or cancel/no-show an irresponsible number of appointments, Vita Serenity Counseling, LLC. may terminate your case due to noncompliance with treatment. I**f you arrive more than 15 minutes late for an appointment, you will be responsible for payment in full and your session will be rescheduled for a later time or date. Sessions will not begin more than 15 after the scheduled time. Any appointments that are missed without 24-hour notice and traditionally would be paid for through an insurance benefit are the full responsibility of the client and /or parent/guardian. In the case of an emergency, you authorize a representative of Vita Serenity Counseling, LLC to notify you at a previously agreed upon number regarding any appointment changes that may occur.

***Please Initial: _____**

CONTACTING Vita Serenity Counseling, LLC : Your therapist at Vita Serenity Counseling, LLC cannot be available at all times. Office hours are by appointment only and the therapist will be available Monday through Friday during office hours. All telephone calls are returned within 24 hours, with the exception of weekends and Holidays. A message can always be left on a confidential, office voicemail and your call can be returned during working hours. E-mail is only an appropriate method of communication for non-therapeutic issues such as appointment rescheduling and shall never be used for therapeutic means. E-mail responses shall be returned as soon as possible, generally within 48 hours of receipt. **In the event of an emergency that is a threat to life or health, please dial 911 for immediate assistance or contact the Crisis Center of Tampa Bay by dialing 211.**

***Please Initial: _____**

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no information will be shared.

____You may inform my physician ____ I decline to inform my physician

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

***Please Initial: _____**

_____

Signature of Client Date

_____

Signature of Parent/Guardian Date

_____

Signature of Parent/Guardian Date

_____

Signature of Therapist Date