Louisville Seminary Counseling Center (LSCC)

Informed Consent / Limits of Confidentiality / Video Release

Informed Consent

1. Louisville Seminary Counseling Center (LSCC) provides counseling for individual, couple, and family issues, including matters of religious concern. I agree to participate in therapy with counseling interns or other clinical staff.

2. LSCC is not an emergency crisis center. In the event of an emergency, I understand I can contact the **"Hope Now" Hotline at 589-4313** or go the Emergency Room of the nearest hospital.

3. I understand that all information about the counseling relationship will be used responsibly by the clinical staff of the LSCC. When ending my connection with LSCC, only official documentation and progress notes will be retained.

4. I understand that if my therapist feels at any point that assistance by additional or other professionals or outside resource persons would be helpful or necessary, they will make the needed referrals.

5. I understand that the fee for my first session is $20.00. Future fees will be based upon my average monthly income and my ability to pay. Counseling fees range from $10.00 to $65.00 as established with my therapist. I can discuss any financial assistance I may need with my therapist.

   I agree that the fee per session will be _____. I understand that payment is expected at the time of service. Appointments may be changed or canceled without charge, provided a 24-hour advance notice is given by calling 502 / 894-2293. If such notice is not given, the session fee will be charged to my account. LSCC accepts checks or cash as payment. I understand I am responsible for reimbursing any returned check fee incurred.

   Who will be responsible for charges incurred? _____ Client _____ Other (please list contact information below)

   Name: _____

   Address: _____

   _____

   Phone: _____

6. My therapist will discuss the following with me:
   a. The specific procedures to be used in therapy and their purposes.
   b. The role of the therapist and client in treatment.
   c. Benefits and specific discomforts or risks reasonably to be expected.
   d. Alternative methods of treatment for the same problem that may produce similar results.
   e. The client's right to ask questions about the nature and process of therapy at any time.
   f. The client's right to end therapy at any time.

Client's Initials: _____

Limits of Confidentiality

Information discussed in the therapy setting is held confidential and will not be shared without written permission with the following exceptions under Kentucky law:

1. The client threatens suicide.
2. The client threatens harm to another person(s).
3. The client reports suspected abuse or neglect, including but not limited to, physical and/or sexual abuse of a child, of the elderly, or of a spouse.
4. The client reports sexual exploitation by a therapist.
5. There is issuance of an order by a court.
6. The client has granted written permission.

Therapists receive clinical supervision and participate in team consultation. Therapy sessions are discussed with clinical staff and professional colleagues at the Louisville Presbyterian Seminary. Clients may be invited to participate in team consultation meetings.

Communications between the clinician and client will otherwise be deemed confidential.

Client's Initials: _____

Video Release

All therapy sessions at LSCC are recorded electronically as standard practice for this agency. I understand sessions may also receive direct live supervision/observation with my knowledge and permission.

LSCC values the confidentiality of counseling sessions and electronic recordings. Clinical information and video recordings will be used only for educational purposes and to assure quality of therapeutic care at LSCC. All electronic recordings of counseling sessions are destroyed upon client discharge from care by this agency.

Client's Initials: _____

My signature below indicates I understand the above **Informed Consent, Limits of Confidentiality**, and **Video Release**. I have been informed about the Counseling Center policies. I may ask questions regarding the policies at any time. Furthermore, my signature validates my consent for myself (and for individuals under my guardianship) to receive treatment at the Louisville Seminary Counseling Center.

_____ _____

Printed Name of Client or Guardian Date

_____

Signature of Client or Guardian

_____ _____

Signature of Therapist Date