John Michalka, MA, LPC, NCC, NBCCH

1415 Elbridge Payne Rd.
Chesterfield, Mo. 63017
314-439-1290
john.michalka@cvcstl.com

INFORMED CONSENT FOR COUNSELING SERVICES

Name: _____Date:_____

Your Therapist: My name is John Michalka and I am a therapist/counselor licensed in the state of Missouri (License No. 2015035430). Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name. My office is located at 1415 Elbridge Payne Rd., Chesterfield, Mo. 63017.

Confidentiality. I understand that all information disclosed within sessions is confidential and may not be revealed to anyone outside the therapist office without my written permission. The only exception is in situations where disclosure is required by law:

1. If my counselor has good reason to believe I may cause harm to myself or others.
2. If my counselor has good reason to believe there is an indication of abuse of a child or dependent or elder adult.
3. If by court subpoena.

☐ I have been given the *Notice of Privacy Practices* which describes how my health information may be used and disclosed and how I can obtain access to this information.

Signature: _____

Electronic Communication (email/text). With respect to electronic communication, I am cautioned that when communicating through email or text, or other electronic means, confidentiality and/or privacy cannot be guaranteed. Communication through these avenues should be limited to scheduling/administration matters. Email/texting communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions.

Audio and video recording. I understand that my sessions may be audio and/or video recorded, and these recordings will be used solely for the purpose of consultation, training, and/or supervision. The recordings will be treated and stored confidentially and erased after they are used. I will address any concerns I have about recordings with my counselor. **I will never be recorded without my permission.**

☐ I consent to be audio/video recorded. Signature:_____

☐ I do not consent to be audio/video recorded.

Emergency. Calls to the main line (314-439-1290) are generally answered by voicemail. I understand that in emergency situations I may not be able to reach my counselor through the main line. If I am experiencing an emergency and cannot reach my counselor, I will call Life Crisis Hotline (314-647-4357), call (911), or proceed to my nearest emergency room.

Risk and benefit. I understand that there is a possibility of risks and benefits that may occur in counseling. Counseling may involve the risk of remembering unpleasant events and may arouse strong emotional feelings. Counseling can impact relationships with significant others. The benefits from counseling may be improved ability to relate with others; a clearer understanding of self, values, and goals; increased academic and job productivity; and an ability to deal with everyday stress. Taking personal responsibility for working with these issues may lead to greater growth.

Referrals. If I believe that your concerns are beyond my scope of competence, you will be given referrals to resources more appropriate to your needs and goals. If my services are abused or misused in any manner (i.e. noncompliance with treatment, frequent missed appointments, delinquent payment, etc.), I reserve the right to deny treatment and appropriate referrals will be given.

Appointments. Individual sessions are 50 minutes; couples/families may be 50-80 minutes; group sessions may be 90-120 minutes. I understand a 24-hour notice is required when canceling appointments and if I cancel without such notice, I agree to pay the cancellation fee of $45.00 for the appointment. In addition, I am responsible for coming to my session on time. If I am late, I understand that my appointment will still need to end on time.

Appointment reminders can be sent via text or email.
☐ Yes, I would like appointment reminders sent to me via text and/or email. **Initials** _____

Payments. I agree to pay $_____ for each ☐ 50 $_____ ☐ 80 minute session. I understand that fees are to be paid to my counselor at time of service in the form of cash, check, or credit card. I agree to inform my counselor of any change in my financial circumstances. I understand that I will receive at least 30 days notice before any fee increase.

Authorization for Filing Insurance. I authorize the release of any medical or other information to process insurance claims. I authorize the payment of medical benefits to John Michalka.

I HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS I HAVE ABOUT THIS INFORMATION:
Client/Guardian signature: _____
Date:_____

I HAVE DISCUSSED THIS INFORMATION WITH MY CLIENT:
Counselor signature: _____
Date:_____

File Copy
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Client Copy
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