Angela Rene Brown, LCSW, LLC

Counseling for *Serenity*

INFORMED CONSENT pg1/2

Thank you for choosing Angela Rene Brown, LCSW & Counseling for Serenity. Today's appointment will take approximately 45 – 60 minutes. We realize 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 and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Angela Rene Brown has earned a Bachelor of Science Degree in Social Work and a Masters Degree in Social Work from the Jane Addams College of Social Work at University of Illinois at Chicago. She is licensed by the State of Illinois as a Licensed Clinical Social Worker. She has over 20 years of clinical experience in treating children and adolescents using individual and group therapy and in working with adults and families. Angela Rene Brown uses cognitive-behavioral therapy and psychodynamic therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse. By Illinois State Law, We are obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs us that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. In the unlikely event that Angela Rene Brown is unable to provide ongoing services, Debra Hirschberg, LCSW will provide those services and will maintain your records for a period of 10 years. Debra Hirschberg may be contacted at 847-612-4309. If an emergency situation for which the client or their guardian feels immediate attention is necessary and Angela Rene Brown is unable to return a call within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Angela Rene Brown will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and she may not be able to respond.*

Signature(s)_____Date:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the HIPPA Notice of Privacy Practices and Client Rights document. May we contact you at home?* ***Yes___ No__*** *May we contact you by your cell?* ***Yes___ No___*** *May we contact you at work?* ***Yes ____ No___*** *Where may we contact you? _____*

Signature(s)_____Date_____

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. We ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Angela Rene Brown, LCSW.*

Signature(s)_____Date_____

If you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed $60 for the session. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. ***You may have a copy of this form if requested.***

Signature(s)_____Date_____

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 inform will be shared.*

_____YES, you may inform my physician(s) _____NO, I decline to inform my physician
PHYSICIAN NAME:_____CLINIC:_____
ADDRESS:_____
PHONE:_____

Signature(s)_____Date_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:
I/We consent that _____ maybe treated as a client by Angela Rene Brown, LCSW. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Signature(s)_____Date_____