www.tampabay-counseling.com
Chuck Crouse, MA, CRC, MBA, CPA 3825 Henderson, Blvd. Tampa, FL. 33629
Registered Mental Health Counselor Intern 813.344.1671 Suite 405
Registered Marriage & Family Therapist Intern chuck@tampabay-counseling.com

Therapy Agreement, Policies & Consent

PART I - ABOUT ME & GENERAL

- Master's in Rehabilitation and Mental Health Counseling – University of South Florida 2018
- Graduate Certificate in Marriage and Family Therapy - University of South Florida 2018
- Registered Marriage and Family Therapist Intern -FL 2019 (IMT 3243).
- Registered Mental Health Counselor Intern -FL 2019 (IMH 19048)
- Certified Rehabilitation Counselor - 2018.
- Certified Clinical Trauma Professional - 2020
- Master of Business Administration – Clemson University 1993
- Certified Public Accountant – FL 1993 (AC0026026)

I am a Florida Registered Intern (pre-licensed professional) providing psychotherapy services under supervision. I provide mental health and relationship counseling to individuals, families and couples. Prior to opening my own practice my experience included adolescents, young adults and families in a community setting.

SUPERVISION/REGISTERED INTERN: WHAT DOES THAT MEAN

Until I have met a minimum number of hours and number of years providing face to face counseling and therapy services, I meet regularly with a qualified supervisor in the field to discuss case progress, treatment plans, and ethical issues. As such the progress of your treatment may be discussed with my supervisor and or other peers in supervision. My supervisor may also review clinical notes. These discussions and case reviews are done in a confidential setting whereby **personally identifiable information is <u>not</u> shared**. Supervision is similar to consulting with a professional peer whereby each professional can learn from the other and create or modify treatment based on the uniqueness of the individual client.

SUICIDAL IDEATION/SECOND ASSESSMENT

If you are having suicidal thoughts it is **very important that we discuss them** as a part of therapy. In these cases, I will often ask you questions to assess your safety and the level of risk to yourself. I will also discuss safety plans even if your risk is assessed low. Often these intrusive thoughts stem from despair or other difficulties and can be important information to your therapy. Not sharing would leave the therapist without important information for your care. Often these thoughts do not go beyond just quick passing thoughts.

As an Intern I am not able to directly initiate a Florida Baker Act. However, for your safety, and the alliance of our relationship, I will take the steps to discuss your responses with a licensed professional prior to you leaving my office (when practical this will be done without identifying you). If we assess your risk level above the lowest level, I may require that you be assessed with another professional prior

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to leaving my office. I will communicate this and be with you throughout this assessment. In the rare event I am unable to timely get another licensed professional to assist in the assessment, or we have assessed you as a high risk of harming yourself, I will be required to contact a law enforcement agency to make an assessment. By agreeing to use my services you agree to these potential exceptions to confidentiality.

For the reasons above, I will be unable to engage in, or continue, a therapy relationship with individuals who disclose they are experiencing suicidal ideations that are above the lowest levels of risk of self-harm.

In emergency situations, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255 or simply dial 911 if either you or someone else is in danger of being harmed.

CONSULTATION

In addition to the above discussion on supervision and suicidal ideation, I, as do other psychotherapists, consult regularly with other professionals regarding clients; however, each client's identity remains completely anonymous and confidentiality is fully maintained.

METHODS OF COMMUNICATION / OFFICE HOURS

- **PHONE is my preferred method of communication.** Office hours are generally from 8:30am to 5;30pm, Monday & Wednesday and from 8:30am to 7:30 pm Tuesday & Thursday **by appointment only.** Friday & weekend hours are scheduled periodically. If you need to contact me for any reason please call 813-344-1671, leave a voicemail, and I will get back to you within 24 -48 hours. I check my messages a few times during the office hours only, unless I am out of town. **In emergency situations,** you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255 or simply dial 911 if either you or someone else is in danger of being harmed.

  **If you call me or I call you, please be aware that unless we are both on landline phones, the conversation may not be secure. Therefore, I try to limit phone conversations to appointments and housekeeping issues only as much as possible.

- **TEXT messaging via mobile phone** is acceptable for appointments and housekeeping issues only. I will not respond to personal and clinical concerns via text.

- **E-MAIL** is acceptable for appointments and housekeeping issues. For journaling and information between sessions e-mail is also acceptable, **as long as your using encrypted e-mail**, but please know that I may not have the opportunity to review your journal e-mails until our next scheduled session. I utilize G-Mail under a Business Associate Agreement (BAA) to comply with HIPAA privacy rules.

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AUDIO OR VIDEO RECORDING

Unless otherwise agreed to by all parties beforehand, there shall be no audio or video recording of therapy sessions, phone calls, or any other services provided.

RECORDS AND YOUR RIGHT TO REVIEW THEM:

Both the law and the standards of my profession require that I keep treatment records for at least 7 years (for minors its 7 years after attaining age 18). Please note that clinically relevant information from emails, texts, and faxes are part of the clinical records. Unless otherwise agreed to be necessary, I retain clinical records only as long as is mandated by Florida law. If you have concerns regarding the treatment records, please discuss them with me. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case, I will provide the records to an appropriate and legitimate mental health professional of your choice with written permission. Considering all of the above exclusions, if it is still appropriate, and upon your request, in writing, I will release information to any agency/person you specify, unless I assess that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from **all** the adults (or all those who legally can authorize such a release) involved in the treatment.

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PART II -
THE PROCESS OF THERAPY / GOALS / EVALUATION AND SCOPE OF PRACTICE

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. **You therefore agree to engage in the counseling process as an important priority your life.** Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. **Change will sometimes be easy and swift, but more often it will be slow and even frustrating**. **There is no guarantee that psychotherapy will yield positive or intended results.** During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, cognitive, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I **provide neither custody evaluation recommendation** nor medication or prescription recommendation nor legal advice, as these activities do not fall within his/her scope of practice.

Many of the treatment strategies I may utilize have received research support for their effectiveness. These interventions stem from numerous therapeutic approaches, including: Emotionally Focused Therapy, Humanistic, Client-Centered, Family Systems Theory, Cognitive Behavioral Therapy (CBT), Brainspotting (BSP), Eye Movement Desensitization and Reprocessing (EMDR), Rational Emotive Behavioral Therapy and Brief Therapies, including, Narrative Therapy & Solution-Focused Therapy. Therapy is individualized to meet your specific treatment needs and goals and is an effective and efficient form of intervention. Ongoing assessment occurs during the therapy process to assist in identifying problems accurately, monitor your progress, and adjust interventions in treatment.

TREATMENT PLANS

Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my experience in employing them, or about the treatment

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plan, please ask and I will do my best to answer them fully. You also have the right to ask about other treatments for your condition and their risks and benefits.

DURATION

Therapy sessions are typically weekly or biweekly for 50 minutes depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed, some clients/challenges may only require 8-12 sessions, or less, while others may be deeply stuck and require many months/years. Others may wish to work on multiple challenges, many will be intertwined while some isolated. Goals may also change. During our work together, we will collaboratively determine from session to session how much longer therapy is recommended. If you have concerns, please address them immediately with me as each of our perception of progress and/or effectiveness of interventions are likely to differ from time to time.

TERMINATION/GRADUATION

As set forth above, after the first couple of meetings, I will assess if I can be of benefit to you. I do not work with clients who, in my opinion, I cannot help, or as addressed above those clients who are above the lowest levels of suicidal ideation. In such a case, if appropriate, I will give you referrals that you can contact. If at any point during psychotherapy I either assesses that our work together **has met** our therapeutic goals **or is not effective** in helping you reach the therapeutic goals or perceive you as non-compliant or non-responsive, I will discuss with you the termination of treatment and conduct pre-termination counseling. In such a case, if appropriate and/or necessary, I would give you a couple of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will give you a couple of referrals that you may want to contact, and if they have your written consent, I will provide them with the essential information needed. You have the right to terminate therapy and communication at any time.

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PART III - CONFIDENTIALITY

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, **except** for the following limitations where personal information may be revealed:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. (Florida statute 39.201). If you reveal information relative to child abuse or child neglect, I am required by law to report this to the appropriate authority.

- **Vulnerable Adult Abuse:** Vulnerable adult abuse or neglect (Florida statute 415.1034). If you reveal information vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.

- **Self-Harm**: Threats, plans or attempts to harm oneself – I am permitted under such instances to take steps to protect your safety which may include the disclosure of confidential information. (Florida statute 491.0147 and Chapter 394).

- **Harm to Others**: Threats regarding harm to another person (Florida statute 491.0147). If you threaten bodily harm or death to another person, I am permitted by law to report this to the appropriate authority.

- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for you records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone and send you an email or letter (if I cannot get in touch with you by phone). If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.

- **Court Ordered Therapy**: If you are in therapy ordered by the court and the court requests records or documentation of your participation in services, the information/documentation that will be discussed/sent on your behalf will be discussed with you prior to information being sent to the court.

- **LITIGATION: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be a legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.**

Client's Name:_____ Client/ Guardian Initials: _____

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- **Written Request**: Your specific request, in writing, to disclose information regarding your psychotherapy to you or to a third party unless I conclude that releasing such information might be harmful in any way (I will discuss my concerns with you and/or the third party. In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), I reserve the right to provide to you or the authorized third party a report of examination or treatment in lieu of copies of the actual records, unless the third party is a treating psychotherapist (Florida Statute 456.057 and HIPAA Privacy Rule). If therapy sessions involve more than 1 party, ALL parties over the age of 18 MUST consent to release of requested information prior to information being released.

- **Inclusion of collateral participants/Couples/Families**: While I will follow the confidentiality standards of the profession, the inclusion of others in therapy either as the client itself in the case of a family or a couple, or the inclusion of a collateral participant (a separate collateral participant form is required), confidentiality by the others in therapy cannot be guaranteed. Additionally, all parties are subject to the exceptions of confidentiality listed above.

- **Families & Couples Counseling as the Client - "No Secret" Policy:** When working with couples, all laws/rules of confidentiality exist. I request that no separate party of the couple attempt to triangulate me into keeping a "secret" that is detrimental to the goal of therapy for the couple. If one party of the couple requests that I keep a "secret" in confidence, I may choose to end the therapy and give you referrals for other therapists as our work and your goals then become counter-productive. Additionally, I ask that all electronic communication be made by copying the other person(s) who comprise the client. If I choose to continue with the knowledge of a "secret" **I will not be able to guarantee such secret will remain undisclosed from others within the client unit.**

- **Dual Relationships & Public**: My relationship with you is strictly professional. In order to preserve this relationship, it is imperative that we do not have any relationship outside the counseling relationship such as a friendship, business, or social relationship. If we have contact in a public setting, I will not acknowledge you in any way that would jeopardize your confidentiality. Should you choose to acknowledge me, I may not be able to protect your confidentiality.

- **Social Media**: If you choose to connect with me on any of my professional (not personal) social media outlets such as Facebook, LinkedIn, Pinterest, Instagram, or Twitter, etc.…you do so at your own risk. I will do my best to protect your identity. By entering into therapy with me you agree to not comment on pages or posts. If you choose to do so you do so at your own risk and I cannot be held liable if someone identifies you as a client.

- **Online reviews**: Making a testimonial, review or rating online may result in you inadvertently revealing personal information about our relationship. I do not monitor these sites, nor do I have the ability to screen or change information you may post therefore you should carefully make your own decision prior to making a testimonial that might allow someone to identify you. If you desire to provide a testimonial, please consider the use of a pseudonym that does not link to you

personally. If you have a complaint or critical feedback, I welcome you to discuss it in session and/or contact me directly (see part V).

- **E–Mails, Cell Phones, Texts, Computers, And Faxes**: Computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and therefore can compromise the privacy and confidentiality of the information used in such communications. Servers and telecommunication companies often have direct and unlimited access to all the information contained in the e-mails, texts and e-faxes that use their services. They may also have location services that you may provide identifying information. Text and e-mail are not secure because electronic devices may be lost or stolen. I have entered into a Business Associate Agreement with Google and use Google's G-mail as my primary business e-mail (chuck@tampabay-counseling.com). When you communicate with me using unencrypted e-mail, texts or e-fax or via phone messages, you assume the responsibility of the risk that your information and identity may be intercepted. If you choose to communicate with me using e-mail or SMS/text messaging, you are advised to use personal email and SMS/MMS addresses rather than those associated with your work accounts. Employers often have the right to look at your work accounts. **Please do not use texts, e-mail, voice mail, or faxes for emergencies as they will not be accessed in a timely manner**.

- **Internet searches**: It is not a regular part of my practice to **search for client information online** through search engines such as Google or social media sites such as Facebook. **Extremely rare exceptions may be made during times of crisis.** If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone or e- mail) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

- **Fee Dispute. See part IV:** I may provide information that identifies us entering into a therapy agreement to a credit card company or collection agent in the event there is an amount due or a dispute.

- **Patriot Act/National Security**: Under certain circumstances agents of the United States Government may be permitted to receive information regarding your psychotherapy without your written consent and/or notice to you that such information has been requested. The gag order provisions of the patriot act may prevent me from disclosing to you that such information has been requested/disclosed, if I were to receive such a request. To the extent possible I would first consult legal counsel to determine the least permissible disclosure required and act, if possible, to limit such disclosure. However, the secrecy, and evolution, behind this area of the law makes it impossible to know how much information can be limited and, accordingly, I cannot guarantee confidentiality of your records if requested under these provisions of the law.

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PART IV – APPOINTMENTS / CANCELATIONS /FEES

APPOINTMENTS: You are responsible for attending each appointment you agreed upon. Appointments may be scheduled over the phone and on www.tampabay-counseling.com. From time to time I will schedule seminars, vacations and time off. If you feel you will need to see someone during these times, we can discuss alternative arrangements in advance of this time off. If I become ill or have to attend to an emergency, I will contact you as soon as possible. If I am unable to contact you directly due to circumstances out of my control, I will have a colleague or another person whom is under my employment contact you to cancel or reschedule an appointment.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours (2 days) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. You authorize me to charge your credit card on file for the amount due. Most insurance companies do not reimburse for missed sessions.

I reserve the right to terminate our counseling relationship if more than 2 sessions are missed without proper notification.

FEES: I operate on a sliding scale whereby we assess ability to pay. **Generally, my private pay rate is $60 for the initial 80- minute assessment and $40 per 50- minute session. Couples/ Family therapy sessions are often 80 minutes at a rate of $70 per session ($50 per 50- minutes).** My practice is "fee for service" and that means that fees are due at the time of your appointment. Additional time will be charged in 15-minute increments. Payments are to be made immediately following each session or previous to the session if distance counseling. **UNTIL ADJUSTED IN WRITING WE HAVE AGREED THE 50-MINUTE RATE SHALL BE $____ AND THE 80-MINUTE RATE SHALL BE $____ UNDER THIS AGREEMENT.**

I accept cash, checks, debit cards and credit cards. If there is a returned check, the charge will be $35. If you indicate that a third party will be paying for any portion of your bill, an Authorization for Release of Confidential Information would need to be signed. This would allow me to contact that individual and share information regarding your billing/ payment arrangements. **Please be aware that if your outstanding balance exceeds $100, I will not be able to schedule further appointments until the balance is paid.**

I charge my hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed at your next session or to your credit/debit card on file.

Fee Disputes: In the case of a credit card dispute, I reserve the right to provide the needed and adequate documentation i.e. your signature on the "Therapy Agreements and Consent" that covers the cancellation policy to your bank or Credit Card Company should you dispute a charge that

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you are financially responsible for. If you have a financial balance, you will be sent a bill to the home address on the intake form unless you advise me otherwise.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. Please know if I get called into court by you or your attorney, **which I strongly suggest not being involved in court in order to protect your confidentiality**, you will be charged $250/hour which will include travel to and from the courthouse, time in court, waiting for the court hearing, preparation for documents, etc. A proposed invoice will be drawn up and you will be required to pay prior to the appearance. Any amount that is due to Tampa Bay counseling, LLC or needs to be returned to you after the appearance will be due/returned within 2 calendar weeks.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records they will be dispensed at 25 cents per page plus a prorated amount of our agreed 50-minute hourly rate based on time involved. Payment for your medical records will be due prior or upon receipt of them and can be picked up at our office please allow at least 2 weeks to prepare your records. You will also need to sign a release for medical records to be dispensed to either you or designated party, and I reserve the right to provide a summary of process notes, in lieu of the actual notes, as described above.

HEALTH INSURANCE

I Currently Do Not Accept Direct Insurance Payments

OUT-OF NETWORK AND HSA REIMBURSEMENTS: Some health plans allow for reimbursement of my fees. It is your responsibility to obtain the necessary forms and provide me with the requirements of your plan. I will be happy to fill out these forms however the extra time required may reduce the amount of time available for our session or require additional prorated fees. In some cases, I may be required to provide a diagnosis. See below for potential reduced confidentiality and negative impacts of a diagnosis.

PRE-AUTHORIZATION AND REDUCED CONFIDENTIALITY: When visits are authorized, usually only a few sessions are granted at a time. When these sessions are finished, your therapist may need to justify the need for continued service potentially causing a delay in treatment. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if you do not feel you have achieved your therapeutic goals. Your insurance company may request or require additional clinical information that is confidential in order to approve or justify a continuation of services. The information they may request may include: treatment plans, progress notes, and at times the entire medical record is requested. I cannot assure or guarantee your confidentiality when an insurance company requires this information. Even if the therapist justifies the need for ongoing services your insurance company may decline services regardless if you think you need continued therapy or not. You are at the mercy of your insurance company to decide your care. You should be aware that some of your personal information might be added to national medical information data banks. For these and other reasons, many therapists openly talk about "the myth of confidentiality" whenever insurance companies become part of the therapeutic process.

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POTENTIAL NEGATIVE IMPACTS OF A DIAGNOSIS: Insurance companies require the therapist to give you a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") in order to get reimbursed.
Psychiatric diagnoses may come back to negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations that require revealing that you have a mental health disorder diagnosis. This includes but is not limited to applying for job applications, applying for financial aid, and concealed weapons permits.
5. A psychiatric diagnosis can be brought in a court case such as a family law, criminal, etc.

It is important for you to know some of the ways having a diagnosis can impact you, so you can empower yourself in regard to your health and medical records. At times having a diagnosis can be helpful such as in the case of a child needing extra services in the school system or a person being able to receive disability.

PART V - COMPLAINTS OR DISPUTES;

- If you do have a complaint or concern about my services and you are not comfortable discussing the matter with me you may make an inquiry with my supervisor (I will provide the name upon request) or to my license/ certification boards (Florida Board of Clinical Social Work, Mental Health Counseling and Marriage & Family Therapy, Florida Certification Board and National Board of Certified Counselors).

- All Disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pre- condition of the initiation of arbitration. **The amount of liability under such a dispute shall be limited to the amount of fees collected during our relationship.** The mediator shall be a neutral third party chosen by agreement of Chuck Crouse/Tampa Bay Counseling, LLC and the client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that a mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

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EMERGENCY CONTACT:

It is necessary that **Tampa Bay Counseling, LLC (Chuck Crouse)** has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name	Relationship	Phone Number(s)

Please check here that you agree and sign below. Thank-you.

☐ I agree to allow **Tampa Bay Counseling, LLC (Chuck Crouse)** to contact my emergency contact on my behalf in the case of emergency

Signature	Date

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CONSENT

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with **Chuck Crouse**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Chuck Crouse/Tampa Bay Counseling, LLC** to provide counseling services that are considered necessary and advisable.

2. **In the event of Chuck Crouse's death or incapacitation**, I understand that she has a professional will that allows a licensed colleague to act on her behalf in making decisions about storing, releasing and/or disposing of my professional records, consistent with relevant laws, regulations and other professional requirements.

3. **I consent to receiving appointment reminders via email (Standard TLS Encryption).**_____*(initials)* and **corresponding via G-Mail (HIPAA compliant email with enhanced encryption)**_____*(initials)***.**

4. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Chuck Crouse to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Chuck Crouse** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name of Minor Child	DOB	Date

** Your signature also signifies that you have received a copy of the "Therapy Agreement and Consent" for your records. If you initially received this paperwork through email it will be considered that you have an electronic copy. If you did not receive this through email you can be provided a copy per your request.*

Printed Name	Signature	Date

_____

Witness – *Date*

Client's Name:_____Client/ Guardian Initials: _____

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Registered Marriage & Family Therapist Intern chuck@tampabay-counseling.com

CLIENT COPY

1. I have read and understand the information contained in the consent and therapy agreement. I have discussed any questions that I have regarding this information with **Chuck Crouse**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Chuck Crouse/Tampa Bay Counseling, LLC** to provide counseling services that are considered necessary and advisable.

2. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Chuck Crouse to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Chuck Crouse** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session. If you are enrolling a minor in therapy (under age 18), please review my "minor therapy agreement" for more specific information and to address best practice standards when working with a minor.

Printed Name of Minor Child	DOB	Date

** Your signature also signifies that you have received a copy of the "Therapy Agreement and Consent" for your records. If you initially received this paperwork through email it will be considered that you have an electronic copy. If you did not receive this through email you can be provided a copy per your request.*

Printed Name	Signature	Date

_____ _____

Witness – *Date*

Client's Name:_____ Client/ Guardian Initials: _____