# Stacy Smith Counseling LLC

Stacy G. Smith, MS, LPC
24 Godwin Ave., Suite 210, Midland Park, NJ 07432
Tel: (516)-232-7775
StacySmithCounseling@outlook.com
www.StacySmithCounseling.com

## CONSENT FOR TREATMENT

### Confidentiality

I understand that all services provided are strictly confidential, and no information can be released without my written consent. However, I understand that, *by law*, Stacy Smith is required to break confidentiality in the following cases:

1) There is good reason to believe I am a danger to myself. Stacy Smith has the right to call for emergency services if I am unable to contract for safety.
2) There is good reason to believe I am a danger to someone else. Stacy Smith must take steps to warn the other party of my intentions, and to take measures that will ensure their safety.
3) There is good reason to believe that I am abusing or neglecting a child or vulnerable adult, or if I provide information about someone else who is doing so. Stacy Smith must inform Child or Adult Protective Services.
4) If my records are subpoenaed in a court of law.

I understand that Stacy Smith may occasionally need to consult with other professionals in their areas of expertise in order to provide me with the best treatment. Information about me may be shared in this context without using my name, date of birth, or other personal means of identification.

### Availability

I understand that I am free to leave a voicemail message at any time. While every effort will be made to return my calls within 24 hours, I understand there is no guarantee that my call will be returned immediately. I understand that Stacy Smith does not provide 24-hour crisis service, and that I am urged to call 911, or go to the nearest emergency room, in the event I feel unsafe or require immediate medical or psychiatric assistance.

### Communication

The best way to communicate with Stacy Smith is by phone. E-mail and text message communication is ***NOT*** considered secure. Should I choose to communicate via these methods, I fully understand that all information I communicate, as well as the response I receive, is ***NOT*** protected, and my confidentiality is at risk with an unwanted third party viewer and disseminator. I also understand that E-mail and text messages are not to be used to communicate urgent matters or emergencies.

### Social Media and Community Encounters

Stacy Smith does not accept social media requests from former or current clients. If I happen to see Stacy in the community, I understand that in an effort to maintain my privacy and confidentiality, she

will not acknowledge me first. While I may say hello, I agree to keep the conversation brief, and refrain from discussing personal topics related to my treatment.

## Fees and Payment

I understand that the fee for counseling is $150 per 50-minute session, and that payment is due on the day of service. I understand that if Stacy Smith is *in-network* with my insurance plan, I may use my insurance to cover the cost. However, I understand I will be responsible for all copayment and coinsurance fees, and agree to pay by cash or credit card on the day of service. I understand that if Stacy Smith does *not* accept my insurance, I am responsible for the full $150 fee. Stacy Smith can submit an out-of-network claim to my insurance carrier for possible reimbursement of fees already paid.

## Cancellation and Lateness

I understand that if I must cancel an appointment, I must do so at least **24 hours** in advance. If I miss a session with no advanced notice, or do not call to cancel at least 24 hours before a scheduled appointment, I understand I will be responsible for the *full* session fee of $150, and that insurance *cannot* be used to cover the cost. I understand that if I am late for a session, the time missed will *not* be made up during that session, and I am responsible for the full session fee or copay.

_____ By initialing here, I attest that I have read and understood the Cancellation Policy above, and agree to abide by its terms.

## Credit Card Information

I understand Stacy Smith requires a credit card to be kept on file for the purposes of collecting late cancellation and no-show fees, as well as any balances owed on my account. By providing my information below, I authorize Stacy Smith to use my card for the above-stated purposes.

Card Type: _____
Name on Card:_____
Card Number:_____
Security Code:_____
Expiration Date:_____
Zip Code:_____

Finally, I understand that while every effort will be made to promote successful changes, I recognize that counseling is not an exact science, and that no guarantees can be made with respect to treatment outcome.

My signature below indicates that I, _____ , understand and agree with all statements made above, and agree to allow Stacy Smith to provide me with counseling services.

_____

Name (print) Signature Date