ELISABETH A. EDWARDS, MA, LMHC, LMFT

INFORMED CONSENT & RELEASE OF LIABILITY
ELISABETH A. EDWARDS, MA, LMHC, LMFT

In order to initiate counseling, please read the following agreement. Your signature attests that have reviewed this document with your therapist and that any questions that have regarding the counseling processed have been answered to your satisfaction.

1. I understand that my counselor, Elisabeth A. Edwards, MA, LMHC, LMFT, is a Licensed Mental Health Counselor (MH 9427) and a Licensed Marriage and Family Therapist (MT 2620) working under the laws and rules specified by the State of Florida and/or the Federal Government, where applicable, and as such is a mandatory reporter. I understand that in all other cases, as outlined below, my counseling records are kept confidential according to the laws and rules specified by the State of Florida and/or the Federal Government.

2. **Records:** I understand that my counseling records (files) are kept confidential, except where disclosure is required by law by the professional ethics of the counseling profession (instances of elder abuse or child abuse and instances where there is a threat to harm oneself or another person). The clinical records are the property of Elisabeth A. Edwards, MA, LMHC, LMFT and are deemed records of confidential sessions between counselors and clients. Other than as required by law, these records will only be released subject to the following paragraphs and with the advance, written consent of the client and Elisabeth A. Edwards, MA, LMHC, LMFT.

3. **Therapy Modalities:** I understand that my counselor, Elisabeth A. Edwards, MA, LMHC, LMFT, may be trained in various psychotherapeutic approaches such as Psychodynamic Therapy, Object Relations Therapy, Attachment Therapies, Gestalt Therapy, Existential Therapy, Systems Therapies, Dream Work, Cognitive Behavioral Therapies including, but not limited to, Mindfulness Therapy, Solutions Based Therapy, and Reality Therapy, as well as various Evidenced Based Practices including, but not limited to, Multisystemic Therapy and Trauma Informed Care Practices. I understand that, as with any therapy, my symptoms may increase in frequency, intensity, and duration before they begin to subside. I understand that this is a normal part of the counseling process, and agree to dialogue with my counselor about my symptoms and comfort level of these symptoms throughout the duration of my treatment. I agree to not hold Elisabeth A. Edwards, MA, LMHC, LMFT liable both while receiving treatment and after I am discharged.

4. **Treatment Approaches:** I understand that my counselor, Elisabeth A. Edwards, MA, LMHC, LMFT, utilizes various treatment approaches, such as Animal Assisted Psychotherapy, Art Therapy, Music Therapy, Telehealth Sessions, and various experiential exercises such as, but not limited to, Movement Therapy, and Meditative Therapies, in order to facilitate the counseling process. I understand that my participation in such therapies is purely voluntary and is done within the guidelines of the treatment plan that I have created with my counselor. In the event that I decide that these modalities are no longer beneficial, I agree to let my counselor know. I understand that my counselor and myself may decide that it is best if I transfer to another counselor inside or outside of the practice, in the event that I no longer wish to have these modalities be a part of my treatment plan. I agree to not hold Elisabeth A. Edwards, MA, LMHC, LMFT liable both while receiving treatment and after I am discharged.

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5. **Medication:** Elisabeth A. Edwards, MA, LMHC, LMFT believes in working with the client to find solutions to symptoms that do not always involve medication management. These include, but are not limited to: working on environmental factors, working on internal factors, and implementing self care solutions to help resolve the symptoms. Sometimes, despite the best interventions, medication management will be recommended in order to alleviate symptoms. I agree to dialogue with my counselor, Elisabeth A. Edwards, MA, LMHC, LMFT, regarding any fears or reservations that I may have regarding medication management. If I decline medication management, and my counselor is amenable to this course of treatment, I agree to waive all liabilities associated with the severity of my symptoms for Elisabeth A. Edwards, MA, LMHC, LMFT. I agree to not hold Elisabeth A. Edwards, MA, LMHC, LMFT liable both while receiving treatment and after I am discharged.

6. I understand that in instances of family therapy or couples therapy, information regarding individual sessions will not be disclosed to another party, even if that party is attending counseling sessions with Elisabeth A. Edwards, MA, LMHC, LMFT. If information is revealed in an individual session that is a safety issue with a minor or a therapeutic issue within the couple or family process, a family therapy or couples session may be arranged to discuss the presenting issue within the context of the session.

7. **Payments, Insurance, and Cancellations:** Counseling sessions are generally 50 min in length. If I wish to schedule a longer session, or if my session goes longer than scheduled, I agree to pay for the additional time used in therapy. In some emergency instances, my counselor may be willing to speak with me outside of counseling session or schedule an additional session. In this instance, I agree to pay for this time, if needed. The price of the session, including any deductible or coinsurance payments for insurance, will be determined before I am scheduled. My scheduling of the counseling sessions indicates that I am amenable to the quoted payment amount. If my insurance does not reimburse according to the quoted amount, I agree to pay the balance. The cancellation policy states that I must cancel my appointment 48 Business Hours in advance of my session. Failure to cancel before 48 hours will result in myself being charged the full session rate. Insurance cannot be billed for late cancels or no shows. A courtesy confirmation text is sent by the office. If I know that I will be unable to make my appointment before the confirmation text is sent, I agree to let the office know so that another client may utilize my appointment time. I understand that failure to adhere to these guidelines may result in me losing my regular, repeating appointment time. I also understand that refusal to pay for services will indicate that I am terminating services with my therapist. In this instance, as in other instances, I agree to not hold Elisabeth A. Edwards, MA, LMHC, LMFT liable both while receiving treatment and after I am discharged.

8. In consideration of the benefits to be derived from the counseling, the receipt of which is hereby acknowledged, I hereby release, remise, and forever discharge and covenant not to sue or hold legally liable Elisabeth A. Edwards, MA, LMHC, LMFT from and all claims, demands, damages, actions, or causes or action whatsoever related to the counseling process.

9. I waive any right I may otherwise have to seek to use my counseling records with Elisabeth A. Edwards, MA, LMHC, LMFT except as may otherwise by agreed upon in writing, in any judicial proceeding or to compel the testimony of any Counselor or Supervisor associated herewith. If testimony is required, I agree to pay two and half times the normal hourly rate for any and all of these individuals for their testimony, and preparation therefore.

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I have read and understood the preceding information and agree to the terms and conditions as stated herein. I understand that these comments are a prerequisite to my receiving and continuing counseling services.

CLIENT NAME: ____

CLIENT SIGNATURE: ____

DATE: ____________________

PARENT / GUARDIAN NAME: ____

PARENT / GUARDIAN NAME SIGNATURE: ______________________________________

DATE: ____________________

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FOR OFFICE USE ONLY

IS THIS PERSON UNDER 18? YES NO

DID THE PARENT OR GUARDIAN SIGN THIS CONSENT FORM FOR THE FILE? YES NO N/A

THERAPIST: ____

THERAPIST SIGNATURE: ____

DATE: ____________________