RK Counseling PLLC 4604 N Penngrove Way Suite 110,Meridian, ID 83646

CONDITIONS OF SERVICE AND CONSENT FOR TREATMENT

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

The following are rights and responsibilities for entering into a professional counseling relationship. This is to assist you (also referred to as "client") in making an informed decision about the therapeutic services being offered.

Therapist Qualifications:

Rikki Davlin ("therapist") is a master's level Licensed Clinical Social Worker. She has experience and training in working with couples, families and individuals. If therapist is unable to meet your needs an appropriate referral will be made.

Therapy Services:

By signing this form, you acknowledge that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO YOU concerning the outcome and/or result of any therapy services. The therapeutic process consists of using experiential and person centered therapy to increase self-awareness for clients. Different therapeutic interventions may be used; including Cognitive Behavioral Therapy (CBT), Acceptance Commitment Therapy (ACT), Dialectical Behavioral Therapy (DBT), and Eye-Movement Desensitization and Reprocessing (EMDR). However, the focus will be in the *here and now* to help clients increase awareness to make their own choices. Sometimes this will include discussing painful or upsetting events which may create discomfort or intense emotional responses. The client has a right to terminate the relationship and a referral will be provided.

Benefits and Risks:

By signing this form, you consent to therapist performing therapy services, including therapeutic interventions listed above, as therapist may deem reasonably necessary or desirable in the exercise of their professional judgment, including those therapy services that may be unforeseen or not known to be needed at the time this consent is obtained. Patient acknowledges that Patient has been informed in general terms of the nature and purpose of the therapy services, the material risks of the therapy services, and practical alternatives to the therapy services, if any. Risks of therapy may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to significantly reduce feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

Confidentiality:

The information shared and discussed in therapy sessions is kept confidential with the following **exceptions**:

- If you indicate that you are going to harm yourself or someone else.
- If you disclose abuse of a child or dependent person.
- If court order to disclose information to a judge or lawyer.
- If otherwise allowed or required by applicable state and/or federal law.
- If you consent to the release of the information.

Therapist reserves the right to conduct consultation with other professionals for the purpose of supporting treatment needs; however, no identifiable information will be shared without prior written consent. If entering the counseling relationship as a couple or family, there is no confidentiality between participants. Therapist reserves the right to disclose none or any information to the participants entering this agreement.

Logistics:

1. Therapy appointments are set for 30, 45, or 55 minutes. **Late shows, 15 minutes or more after the appointment is set, will be rescheduled and a $25 fee assessed at the next session.**
2. Please call with at least 24 hour notice if you decide that you cannot keep the appointment.
3. Attendance to all scheduled appointments is expected. Failure to no show or late cancel up to **2** appointments within a short period of time may result in a termination of your relationship with therapist and your case being referred to another mental health professional.
4. Continuation of services is dependent upon satisfactory participation in therapy sessions along with consistent payment at time of services rendered.

Validity of Form:

Client acknowledges that a copy, or an electronic version of this document may be used in place of and is as valid as the original. Therapist will rely

on your documented medical history, as well as other information obtained from you, your family or others having knowledge about you in determining whether to perform or recommend therapeutic interventions. You agree to provide accurate and complete information about your medical history and conditions.

By signing this form you confirm that you have read and understand and accept the terms of this document. By signing this form you confirm you are the client or the client's legal representative, or is duly authorized by the client as his or her general agent to execute the above and accept its terms.

In case of an emergency or crisis, call 911 or the Suicide Hotline 1-800-273-8255.

Parent Consent for Treatment of Minor: (*Leave Blank if Patient is Not a Minor*)
Duration of this Consent:

- ❑ This authorization will remain in effect until the 18th birthday of listed minor
- ❑ For this visit only
- ❑ This authorization shall remain in effect until _____, 20____, unless sooner revoked in writing and delivered to RK Counseling, PLLC.

By signing below, you acknowledge the information discussed above and consent to treatment being provided by RK Counseling, PLLC.

_____
Patient Name and Date of Birth

_____ _____
Signature *If applicable,* Print Parent/Guardian/Other Client Name

_____ _____
Signature Date *If applicable,* Signature Date

_____
Therapist's Signature Date
Rikki Davlin, LCSW