Shannon Brown Counseling, PLLC
Licensed Marriage and Family Therapist
17100 N 67th Ave, Suite 400
Glendale, AZ 85308

Informed Consent to Treatment:

Please read and sign that you have read and understand the material and agree to the conditions set forth herein:

I hereby authorize Shannon Brown to notify the referral source of my having made this appointment. This alone will be disclosed to the referring professional and is done only as a professional courtesy.

I understand the purpose of treatment is to restore and improve functional behavioral health through therapeutic modalities including, but not limited to, individual and/or family therapy, cognitive behavioral interventions, and encouraging the use of community resources and informal supports.

I am aware I may stop treatment at any time. I understand no promises have been made to me as to the results of treatment or recommendations provided by Shannon Brown.

I understand by terminating services against the advice of my treatment team, I may not fully benefit from resolution of symptoms for which I sought treatment. It is my right to participate in treatment decisions and in the development and periodic review and revision of the treatment plan.

I am aware it is my responsibility to discuss concerns of care with Shannon Brown. If issues remain unresolved and are believed to be an ethical or legal violation of the therapeutic contract, I may file a complaint through my behavioral health insurance company and/or the Arizona Board of Behavioral Health Examiners.

I understand payment is due in full at the time of service. Should my account become delinquent and referred to any third party for collection effort, I agree to pay all reasonable attorney's fees, court costs, and collection expenses of not more than 30 percent of referred balance. Shannon Brown reserves the right to suspend/terminate services until overdue balances are paid. I understand if any questions should arise concerning the status of my account; it is my responsibility to direct such inquiries to Shannon Brown.

I authorize the payment of my insurance benefits directly to Shannon Brown on my behalf. I understand I am responsible for all deductibles, co-insurance and non-covered charges.

I understand patients are seen by appointment only and any cancellations of appointments not made a minimum of 24 hours in advance of the scheduled time may be subject to a fee of 50.00. (Please note, insurance companies do not reimburse for missed appointments.)

I understand Shannon Brown may determine that additional or specialized treatment is clinically necessary (such as psychiatric services and/or medication). In the event Shannon Brown is unable to provide treatment, she will suggest appropriate referrals or alternatives. I am free to choose my own treatment or decline further treatment services. I understand Shannon Brown is not responsible for the cost of any recommended treatment.

I understand Shannon Brown's time devoted to offering testimony in deposition for legal concerns will be compensated at the regular hourly rate paid by your insurance benefits.

I understand identifying insurance and treatment information will be shared with other agencies (i.e. billing companies, scheduling companies, etc.) as required for normal practice.

I understand Shannon Brown's sessions are completely protected by federal confidentiality laws **with the following exceptions**:

1. If any person being treated, threatens violence or harm to him/herself and/or to another person, the appropriate authorities will be contacted to insure the safety of all concerned parties.
2. If reason arises during treatment to suspect ongoing child/elder abuse, this will be reported to the appropriate authorities.
3. If court of law issues a Court Order to release information, Shannon Brown must comply.
4. Shannon Brown may receive consultation or supervision from another professional. If so, your case may be discussed confidentially with another professional.

Information about your case will not be disclosed without your prior, written permission except in the above instances.

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Client Records

Client treatment records are kept for a period of 7 years after termination of therapy or 3 years after the 18th birthday of the client, whichever is longer. You are entitled to a copy of your records, unless viewing the records would cause emotional harm to you. Upon signing a Release of Information form, records may be sent to other providers as you wish.

Limitations of Technology

While technology (i.e. computers, internet, cell phone, email, faxes, Skype, face time, text) are used in the normal course of business, there are also limitations to the confidentiality of such technology. Every reasonable effort is made to secure your information. However, please be aware Shannon Brown's email system and phone are not encrypted. Therefore there is no guarantee of confidentiality using those modes of communication.

Emergencies:

Shannon Brown does not have the capability to respond immediately to emergencies.

Life threatening emergency - call 911.

If you are experiencing a mental health crisis, call the county wide crisis line -602-222-9444.

Informed Consent to Treatment:

I voluntarily consent to examination, treatment and procedures that may be performed as part of my care by Shannon Brown.

Initial: _____

I hereby authorize Shannon Brown to release to any appropriate insurance related entity or collection agency the information needed to process claims for payment in reference to my treatment.

Initial: _____

Please sign and date below to indicate you have read and understand the above and agree to those arrangements outlined concerning your treatment. You have the right to request a copy of this document for your records.

Patient signature:_____Date:_____

Shannon Brown, MC, LMFT _____Date:_____