Client Name: _____ DOB: _____

Legal guardian is to fill out this form if client is under the age of 18.

Counseling Sessions: At Spero Counseling, we provide individual, family, and couples and group counseling. Sessions last approximately 45-60 minutes. Your counselor will make every effort to begin/end on time. If you are more than 10 minutes late for your session, your counselor may not be available. Clients/Guardians are responsible for remembering appointments. If you miss an appointment and do not contact your counselor within 7 days, they will consider it your desire to terminate counseling.

No call/No Show Fee: We require 24-hour notice regarding cancellation of scheduled appointments. Your counselor may charge you for missed appointments or late cancellations. Decisions to waive these fees due to unforeseen circumstances will be considered on a case-by-case basis. Payment of this fee or payment arrangements are required before attending further sessions. It is important to understand that this fee will not be billed to insurance and that you are responsible for it. Note: Fees do not apply to Soonercare clients per OHCA policy.

No show fee:_____ Late Cancellation fee:_____

Confidentiality: Confidentiality is a very important aspect of trust between therapist and client. According to Oklahoma state law, confidentiality and privileged communication generally remain rights of all clients of behavioral health practitioners. However, pursuant to various Oklahoma law, your counselor is required to disclose confidential information if any of the following exist:

- **You are a danger to yourself or others.**
- **Your therapist was appointed by the courts to evaluate you.**
- **You are a minor/vulnerable adult and your therapist reasonably suspects you are a victim of child abuse/neglect.**
- **Your therapist reasonably suspects you have committed child abuse/neglect.**
- **You waive your right to privilege or give consent to limited disclosure by your therapist, either in writing or in court testimony.**

- **When a release of information and/or records is ordered by a court of law.**

- **When a release of information is subpoenaed by supervising government agencies in connection with an investigation, public hearing, health oversight activities or other proceeding.**

- **With your written consent, your insurance company or paying entity requests to review all relevant records.**

Duty to Warn
: Should your counselor believe a client has intent to harm himself and/or someone else, such information will be shared with:

- **The person who is likely to be the victim of potential harm, or**

- **The family/guardian of the client who intends to harm himself.**

- **The parent/guardian if the potential victim is a minor child.**

If for some reason notification of the intended victim is not possible, the practitioner must, by law, do the following:

- **Notify a law enforcement agency in the vicinity where the client or potential victim**
  resides;

- **Take reasonable steps to initiate proceedings for voluntary or involuntary hospitalization,**
  if appropriate;

- **Take any other precautions that a reasonable and prudent mental health provider would**
  take under the circumstances.

Recording of sessions: Due to the confidentiality of sessions, audio/video recording of therapy sessions is prohibited without the consent of every person involved in the

counseling session and advance knowledge of the therapist.

Your counselor may submit insurance claims electronically and in writing and also utilizes the services of professionals for accounting, bookkeeping and technology support purposes. HIPPAA regulations are followed to maintain confidentiality within the parameters of typical business functions.

Consultation with other professionals may be required to ensure a high quality of service to you. In the event that your counselor discusses your case with another professional, no identifying information will be used unless prior authorization has been given by the client.

Several of our providers at Spero are candidates for licensure. If your provider is a candidate you should be aware that they will be under the supervision of licensed mental health professionals. As such, they will be meeting regularly with their supervisors to discuss each of their cases, to receive appropriate supervision of their work, and to obtain necessary consultation in order to provide you with the most helpful and effective mental health services. If information regarding your case is to be shared in a group consultation no identifying information would be utilized. Candidates are required by law to tape occasional sessions as a part of their licensure process. Your permission must be sought and obtained in writing prior to any taping. Tapes are used for supervisory purposes only and are destroyed once supervision is complete. They are never maintained as a part of your record. Your individual treatment provider will seek your permission and inform you when tapings and/or observations are taking place.

In an attempt to maintain your confidentiality, your counselor will not acknowledge you in any way if you were to run into each other outside of my office. If you would like to address your counselor in this instance, you may and they will respond in kind. However, they will not speak with you about any therapeutic issues outside of my office.

Technological forms of communication including email, texting, and social networking are not confidential methods of contacting one's counselor. If you choose to contact your counselor using these methods, it should be with the understanding that your confidentiality cannot be 100% protected.

Fees/Billing: As a private counselor, your counselor will set their own fee schedule.

Fees will be discussed and agreed upon prior to services being provided. You will also be notified prior to any changes in fees. Payments must be made directly to your counselor in the form agreed upon.

IT_____ FT_____ Couples_____ Group_____

Termination of Services: I understand that consent for treatment is voluntary and that I may withdraw from counseling at any time and for any reason. I also understand that my counselor reserves the right to terminate treatment at any time and for any reason. My counselor will make applicable referrals as necessary at the time of termination.

_____**While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.**

_____**I understand I am free to discontinue treatment at any time, unless treatment is deemed mandatory by guardian or legal entity.**

_____**I understand treatment progress is dependent upon my cooperation and participation and agree to notify therapist of behavior/symptom changes.**

_____**I am not aware of any reason why treatment should not proceed as discussed.**

I have read this form, discussed my questions with my counselor, and agree to its terms.

Client/Gaurdian signature _____Date_____

Counselor signature _____Date_____