# **Sharon Becker, LISW, ACSW**

**222 W. Coleman Blvd.**

**Mt Pleasant, SC 29464**

**843-352-3107**

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**Consent for Treatment and Professional Disclosure Statement**

I realize that making the decision to seek counseling is an important one. I take pride in ensuring that clients feel welcomed and at ease as we begin to form the counseling relationship. The following information should assist you in clarifying any questions you may have about my services. Feel free to ask any further questions after carefully reading the information below.

Together we will identify your goals and work on developing a treatment plan that will be most effective for you based on your individual needs. Counseling, in my opinion, is most useful when a client plays an active role in the process and I will assist you in doing so through exercises and assignments that integrate what is learned in treatment between sessions. While there is no guarantee of treatment outcome, building a trusting and open relationship between client and therapist is critical.

***Client Rights and Responsibilities***

**Treatment and Termination of Counseling and Therapy Services:** I understand that in order for treatment to be most effective, I must take responsibility to identify goals to be reviewed as needed during the course of therapy. I understand it is my further responsibility to report on my progress and advise Sharon Becker if I decide to discontinue the counseling process. You have the right to discontinue treatment at any time, without further obligation (except for payment for services already provided). It is my belief that notifying me in order to discuss this decision is most helpful. It is clinically best to have a final session to facilitate termination. If another form of treatment or other counseling professional is desired, I will be happy to provide several referral sources. If you decide to discontinue treatment without notice and there is no contact from you within 60 days, your case will be considered closed and the professional relationship with Sharon Becker will be ended at that time. Your case can be reopened at a later time if you wish to return.

**Conjoint (Couples) or Family Therapy:** If I am seen in conjoint or family therapy as part of my treatment, my signature below gives Sharon Becker permission to discuss information shared during an individual assessment and/or counseling meetings and gives her permission to communicate whatever information she deems appropriate to my spouse, partner or family member. I understand that any authorization for release of information must be signed by both me and my spouse, partner or family member. Please note that some insurance companies do not reimburse for Family Therapy or Marriage Counseling as a treatment option. Review your policy coverage and discuss this with your provider.

**Minors and Wards:** If you are under 18 years of age, the law provides your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they will give up access to your records. If they agree, I will provide them only general information about our work together and will discuss this with you in advance whenever possible. Exceptions would include my assessment that there is a high risk that you are being harmed, will seriously harm yourself or will harm someone else. In this case, I will discuss this with you, if possible, and any objections you may have. We will then discuss the information to be shared with you present at the session if and when this is possible.

***Confidentiality***

You have the right to expect that information you share with me will be held in confidence, as protected by law and the ethical standards as defined by the National Association of Social Workers and its credentialing body. However, it is important for you to be aware that there are several circumstances that confidentiality must be breached including:

* Your file can be subpoenaed in S.C. through a court order (signed by a judge).
* You are threatening self harm or suicide or present an immediate danger to others
* There is a clear risk to commit serious property damage or to commit a serious crime.
* There is a suspicion of child abuse or neglect and or a vulnerable adult has been or is being abused or neglected.
* If you request a release of information
* If the client is under the age of 18 and a parent or legal guardian request a release of information

It is **MANDATORY** and required by state law to report suspected child abuse/neglect, elder abuse/neglect or the abuse/neglect of an otherwise incapacitated person who cannot reasonably be expected to care for/protect him/herself to the appropriate agencies.

If you wish your protected health/mental health information (defined by HIPAA) released to someone (e.g. attorney, physician, workers compensation, etc.), you must sign a**n Authorized Release of Information.**

**Ethics:** Sharon Becker follows the Code of Ethics of the South Carolina Board of Examiners for Licensure of Social Workers and The National Association of Social Workers.

***Fees and Payment Policy***

**Fees**

* Unless we make different arrangements, sessions are typically 55 minutes in length.
* Fees are $120 per session, unless other arrangements are negotiated.
* The initial appointment is an evaluation session, and 50% of the full payment ($60) is to be paid at that time regardless of insurance coverage.

**Payment Policy**

Please select one of the following options. If this changes, it is your responsibility to inform Sharon Becker and renegotiate payment.We do not accept credit cards.

**\_\_\_** I will not be using insurance. I agree to pay by check or cash for each session at the time services are rendered.

**\_\_\_** I will be using my insurance benefits and authorize Sharon Becker to release and receive information necessary to process and expedite my insurance claims.

Sharon Becker is a preferred provider for the following insurance providers: Blue Cross/Blue Shield, Aetna, APS Healthcare (Workplace Options/Network Advantage), Health Management Systems of America. If another insurance company covers you, I will provide billing information for you to file the claim. However, you will be responsible for full payment at the time of the appointment.

**Please initial:** \_\_\_\_\_ I understand that I am ultimately responsible for all charges for co-pay amounts, deductibles, and any services my insurance carrier does not cover.

**\_\_\_** I have been referred by and am utilizing the benefits of the following Employment Assistance Program \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that most EAP services are short term and problem–focused. If further treatment is needed, I will negotiate the fee with Sharon Becker or be referred to another provider.

***Cancellation and Lateness Policy***

I understand I must cancel my appointment 24 hours in advance. If I do not cancel in advance or do not show, I agree to pay the total charge of the negotiated rate for the scheduled appointment time. I understand and agree to this because insurance cannot be filed if the client (s) is not present. If I arrive more than fifteen minutes after the scheduled time, this will be considered a no show unless contact has been made and therapist indicated otherwise. In case of an emergency, this fee will be negotiated.

***Informed Consent***

I have had the opportunity to read and review Sharon Becker’s Professional Disclosure Statement and Consent for Treatment which includes the HIPAA Notice Form. These documents include information about the counseling process, confidentiality, and other important information about the services provided by Sharon Becker. Copies of these documents are available to me at any time. I will be notified of any changes or updates. My signature below indicates that I have read and agree to the terms of these documents and give my informed consent for treatment with Sharon Becker.

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**Client Name and Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If client is a minor, signature of parent Date**

**or legal guardian.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Client #2 Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Signature of Client #3 Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Client #4 Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist Signature Date**