David Barton, MA, LPC
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PRACTICE POLICIES AND INFORMED CONSENT FOR COUNSELING SERVICES

Name: _____ Date: _____

SERVICES AND STAFF: David Barton, MA, LPC is a Masters-level, licensed professional counselor in the state of Missouri. Mr. Barton practices individual, couples, and group counseling with adults.

APPOINTMENTS: Individual sessions are 50 minutes; couples/families may be 50-80 minutes; group sessions may be 90-120 minutes. If Mr. Barton is late to an appointment, the complete 50 minutes will be allowed. If the client is late, the appointment will end at the scheduled time. ***Initials*** _____

WAITING ROOM: You are asked to remain in the waiting room until your counselor comes to greet you. Please note: Children are not to be left unattended in the waiting room.

CANCELLATION POLICY: Cooperation and courtesy are important to the therapeutic process. When you schedule an appointment, that time is reserved for you. It is your responsibility to schedule and cancel appointments. If you fail to appear for the scheduled appointment, or fail to give a 24-hour notice of your cancellation, you will be charged a **cancellation fee equal to your normal session fee.**

I understand a 24-hour notice is required when canceling appointments and if I cancel without such notice, I agree to pay the cancellation fee equal to my normal session fee for the appointment. ***Initials*** _____

PROFESSIONAL FEES: Session fees are $100.00 per 50 min session for individuals and $120.00 per 80 min session for couples. *If the fee represents a financial hardship for you, please discuss this with Mr. Barton.*

Session Fee of $ _____ is due at each session.

Session payments are expected at the time services are rendered (by the end of each session). Acceptable forms of payment are cash, check, Venmo, or PayPal. **Checks are to be made payable to: David Barton, LPC.**

> **Insurance:** At this time, Mr. Barton is not a member of any health insurance plans or panels. If requested, Mr. Barton will supply you with an invoice for services including the times/dates of appointments, fees, and payments made which you may then be able to use to obtain reimbursement from your insurance carrier.

I understand that fees are to be paid to my counselor at time of service in the form of cash, check, Venmo, or PayPal. I agree to inform my counselor of any change in my financial circumstances. I understand that I will receive at least 30 days' notice before any fee increase. If a check is returned for any reason, I agree to replace the payment and return any check fees incurred by David Barton, LPC. ***Initials*** _____

LEGAL PROCEEDINGS: If you become involved in legal proceedings that require Mr. Barton's participation, you will be expected to pay for his professional time, including preparation and transportation, even if he is called to testify by another party. Due to the extensive time investment of legal involvement, Mr. Barton charges $350 per day for preparation, transportation to, and attendance at any legal proceeding.

If Mr. Barton becomes involved in any of my legal proceedings, I understand that fees will be charged to compensate for his time at $350 per day. ***Initials*** _____

CONFIDENTIALITY: Confidentiality is the foundation for counseling. Developing trust and confidence in those who listen and help you is paramount to a successful therapeutic experience. All communications between client and therapist are considered confidential except where legal demands take precedence. No information will be released without your written consent unless mandated by law. In these cases, Mr. Barton will only release information that is necessary to appropriately carry out his legal responsibilities.

Exceptions to Confidentiality:

1. If there is good reason to suspect, or evidence, that you may **present a danger to yourself or others**, legal and ethical standards require that steps be taken to ensure the safety of those in danger. Most of the time, this can be done within the privacy of the office. However, there are occasions when your emergency contact, your family, your doctor, hospital, the potential victim, or even the police must be notified.
2. If there is good reason to suspect, or evidence of, **abuse and/or neglect toward children or dependent adults**. Missouri Law requires therapists to report any suspected cases of child abuse to the Division of Family Services.
3. In response to a **court subpoena/order**.

I understand that all information disclosed within sessions is confidential and may not be revealed to anyone outside my counselor without my written permission. The only exceptions are in the situations mentioned above where disclosure is required by law. ***Initials*** _____

PRIVACY: If deemed to be in the best interests of the client, Mr. Barton may offer outdoor or telephonic sessions. I am advised that these forms of communication are not HIPAA compliant, which means that these methods of contact and counseling do not protect my privacy. I understand that it is my right to reject such services. Because of the nature of the therapeutic relationship, I understand that Mr. Barton cannot "follow" or "friend" me, nor "like" my posts on any form of social media. I understand that his failure to "follow" or "friend" or "like" me via social media is not reflective of his perceptions of me, but of laws and professional ethics. I understand that I may discuss this topic with Mr. Barton at any time. ***Initials*** _____

EMERGENCY CONTACT: Emergencies are urgent issues requiring immediate action. While Mr. Barton is usually accessible during normal business hours, he does not answer the phone when he is with a client or in most public spaces. If you are experiencing an emergency, go to the Emergency Room, call 911, or call the Life Crisis Hotline (314-647-4357).

If I am experiencing an emergency and cannot reach my counselor, I will proceed to my nearest Emergency Room, call 911, or call the Life Crisis Hotline. ***Initials*** _____

NON-EMERGENT CONTACT:

Phone: Calls to Mr. Barton's main office (314.328.4345) are generally answered by voice mail. You may leave a message on his confidential voicemail at any time, and your call will be returned as soon as possible within 24 hours of receiving it. Mr. Barton will make every attempt to inform you in advance of any planned absences and provide you with a name and phone number of the therapist covering his practice.

Electronic contact (e-mail/text): You are cautioned that when communicating through e-mail, text-message, or other electronic means, confidentiality and/or privacy cannot be guaranteed. Communication through these avenues should be limited to scheduling/administrative matters. E-mail/text communication is not to be used to provide/receive treatment services or take the place of therapy sessions.

With respect to electronic communication, I am cautioned that when communicating through email or text, or other electronic means, confidentiality and/or privacy cannot be guaranteed. ***Initials*** _____

RISKS AND BENEFITS OF THERAPY: Therapy has both benefits and risks. **Risks** sometimes include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness. Discussing unpleasant aspects of your life is often necessary in therapy. The therapeutic process often involves change (or at least considering change), which may feel threatening not only to you, but also to others close to you. **However**, therapy has been shown to have **benefits** for individuals who undertake it. Therapy often leads to a significant reduction in 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 that are discussed outside of sessions.

I understand there is a possibility of risks and benefits which may occur in therapy. ***Initials*** _____

REFERRALS: If Mr. Barton believes that your concerns are beyond his scope of competence, you will be given referrals to resources more appropriate to your needs and goals. If Mr. Barton's services are abused or misused in any manner (i.e. noncompliance with treatment, frequent missed appointments, delinquent payment, etc.), Mr. Barton reserves the right to deny treatment and appropriate referrals will be given.

If it is decided that this is not the appropriate agency to meet my needs, I understand that I will be given referrals to resources more appropriate to my needs and goals. ***Initials*** _____

I CONSENT TO THE POLICIES AND PROCEDURES PUT FORTH BY THIS DOCUMENT.
I HAVE HAD THE OPPORTUNITY TO DISCUSS ANY QUESTIONS I HAVE ABOUT THIS INFORMATION:

Client/Guardian signature: _____Date:_____

I HAVE DISCUSSED THIS INFORMATION WITH MY CLIENT:

Counselor signature:_____Date:_____