updated 05/09/2022

AFFINITY COUNSELING LLC

Susan M. Shanks, MDIV MAPC LPC LCPC CAMS-II

1209 17th Ave, Monroe, WI 53566
IL license 180.010588
Monroe Phone 608-426-6463

5508 Clayton Cir, Roscoe, IL 61073
WI license 6311-125
Roscoe Phone: 815-908-9903

INFORMED CONSENT

Thank you for choosing Affinity Counseling LLC with Therapist Susan M. Shanks, LPC LCPC CAMS-II. Today's appointment and future appointments will take 45 to 55 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of Affinity Counseling LLC policies, State and Federal Laws that effect the counseling process, and client rights. If you have any questions or concerns regarding counseling, please ask and I will try my best to provide you the information you need.

Affinity Counseling LLC is a private practice with one therapist. I am that therapist. I hold several degrees. They are a Bachelor of Science in Education from University of Wisconsin, a Masters in Divinity and a Masters in Counseling from Loyola University in Chicago. I am licensed by the states of Illinois and Wisconsin as a Licensed Clinical Professional Counselor. I have over 12 years of clinical experience in treating adolescents, adults and couples using individual and family therapy. I practice standard Cognitive Behavioral Therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan for treatment, and risks will be discussed.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:
Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the office. If no response is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community for those services. Emergency services include: **local Emergency Room, 911 for police/EMS/Fire Department, or 24 Hour Mental Health and AODA Crisis Line at 1-888-552-6642**. Therapist Susan M. Shanks, LPC LCPC CAMS-II, will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.

Signature(s) _____ **Date:**_____

Handicapped Accessibility:
This clinic is not handicapped accessible. The clinic has 2 steps at the entrance. The clinic does have a washroom; however, the door is not large enough to accommodate all wheelchairs. Also, handicap accessibility to this entrance prevents a client from having access to mental health services, other accommodations for services can be arranged upon request.

FINANCIAL/INSURANCE ISSUES: As a courtesy we will bill your insurance company. If you have a co-pay it is due at the time of the session. Payment can be made in form of cash, check, HSA or FSA card or credit or debit card. If a credit or debit card is used, the client pays the card processing fee. In regards to insurance, if the deductible is not met the full, session fee is due at each session until the deductible is satisfied.

If your insurance company denies payment or does not cover counseling, YOU are responsible for the unpaid balance. Clients who fail to show up for their appointment or fail to cancel 24 hours prior to the session are charged a no-show fee of $110.00 for that missed session. In the case of Employee Assistance Program clients, the session will count as a used session. When a check is used to make payment, if the check is returned for non-sufficient funds, a $35 NSF fee per NSF transaction is charged and any other addition bank fees are charged to the client. An account overdue more than 90 days will be turned over to the collection agency for collection. The client is responsible for any additional fees incurred to collect the debt owed to Affinity Counseling LLC. Authorization of payment of medical benefits will go directly to Affinity Counseling LLC/Susan M. Shanks, *LPC LCPC CAMS-II*.

Affinity Counseling LLC sincerely appreciates your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.

Signature(s) _____Date:_____

COORDINATION OF TREAMENT: *(optional)*
It is important that all health care providers work together. As such, your permission is requested to communicate with your primary care physician and/or psychiatrist. Your consent is valid for up to one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no inform will be shared.

_____(initials) I give consent to inform my physician(s)

_____(initials) I decline to have my physician informed.

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

Signature(s) _____Date:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:
I/We have read and received a copy of the Notice of Privacy Practices and Client Rights documents.

Signature(s) _____Date:_____

CONTACT: *(Please circle)*
May I contact you at home: YES or NO ? Leave a message YES or NO?
Phone #_____
May I contact you by cell phone: YES or NO ?Leave a message YES or NO?
Phone #_____
Would you like to receive appointment reminders? YES or NO? Text or Phone or Email

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CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We (parent/guardian) _____ consent that

_____maybe treated as a client by Therapist Susan M. Shanks, LPC LCPC CAMS-II. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. Affinity Counseling LLC asks for your cooperation to provide the most timely treatment for you and/or your children. This consent to treat expires at the end of treatment, if revoked in writing, or after 1 year.

Signature(s) of parent/guardian(s): _____Date:_____