Jean Schwab, LCSW

INFORMED CONSENT

Thank you for choosing Jean Schwab, LCSW, LLC. Today's appointment will take approximately 50 – 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 our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

Jean Schwab, MSW, LCSW has earned a Bachelor of Science Degree in Communications and a Masters Degree in Social Work from the University of Illinois. She is licensed by the State of Illinois as a Licensed Clinical Social Worker. She has over 16 years of clinical experience in treating adolescents, adults and families using individual and family therapy approaches including, but not limited to, Narrative Therapy, DBT, MBCT, and various other therapy modalities. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

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 Illinois 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, and no call is returned within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Jean Schwab, LCSW 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:_____

FINANCIAL/INSURANCE ISSUES: Depending upon the client(s) present in session, sessions are usually billed at_____per 55 minute session. The initial intake session usually runs 90 minutes and will be billed at _____.
Payment by cash, check or credit (Visa, MasterCard) is due at the end of each appointment.

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COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for 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.

____You may inform my physician(s) ____I decline to inform my physician

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 document.

Signature(s)_____**Date**_____

May we contact you at home (circle one) **yes no**? May we contact you at work **yes no?** May we contact you by cell phone **yes no?** Where may we contact you _____?

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ may be treated as a client by Jean Schwab, LCSW. 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. We ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Signature(s)_____**Date**_____