



EMMANUEL BAPTIST

Carla Smith, LSW Licensed Social Worker
License # SW127767
425 Luther Road Phone 814-266-4117
Johnstown, PA 15904 Fax 269-1498

Please make a Copy for your Records.

INFORMED CONSENT DOCUMENT

Seeking professional Psychological and/or Counseling services is a big decision and you may have many questions about this process. My mission is to provide an ethical and competent service. This document is designed to inform you about our policies and your rights and obligations as you participate in this process. At any time, if you do not understand the nature of the services you are receiving you should voice your questions and concerns. I will answer your questions and provide you the information you need.

CONFIDENTIALITY

All information disclosed within sessions and the written/electronic records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law such as:

- If I have good reason to believe that you will harm another person. If I believe that harm is imminent, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services or Adult Protective Service.
- If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call 911.

Also, I consult with other professionals regarding my clients. These consultations are confidential and the client's name or other identifying information is not mentioned. Lastly, records of services received may be obtained under court order. In the event you are participating in couples or family treatment, the nature and limits of confidentiality will be discussed with you.

INITIAL: _____

CONFIDENTIALITY OF EMAIL, CELL PHONE, AND FAX COMMUNICATION

Should you choose to communicate with me by the above mentioned means, you understand that every effort will be made to ensure those communications remain confidential. However, you also accept some measure of risk inherent in the use of these technologies. You must let me know if you desire to avoid or limit the use of any or all of the above mentioned communication devices.

EMERGENCIES

IF you need to contact me between sessions, please leave a message with the office phone at (814)-266-4117 and your call will be returned as soon as possible. **You may call (814)418-4332 in emergencies to reach me directly. If you experience a serious emergency during the course of our work together and I am unable to be contacted, I direct you to contact Cambria County's Crisis Hotline at (814) 535-8531, Somerset County at 866-611-6467, or dial 911 and contact emergency services immediately.**

DONATIONS

Emmanuel Baptist Church is a nonprofit organization. Emmanuel Baptist Church will accept donations for my services from those who attend Emmanuel Baptist Church on a regular basis. If you do not attend Emmanuel Baptist Church on a regular basis you are encouraged to donate as you are able. This is not a fee. Your donation is a tax deductible donation. A receipt will be issued upon request.

CANCELLATION

The scheduling of services involves the reservation of time specifically for you; a minimum of a 24-hour notice is required for rescheduling or cancelling an appointment. You are responsible for coming to your session on time and at the time I have scheduled. Sessions will last approximately 50 minutes. If you are late, we will end on time and not run over into the next person's session.

PROCESS OF THERAPY/COUNSELING AND ASSESSMENT

Participation in treatment can result in a number of benefits to you, including improved thoughts and feelings of well being, improved relationships and resolution of specific issues that led you to seek professional help. Working toward these benefits, however, requires effort on your part. Treatment requires discussing openly and honestly concerns, issues and even unpleasant events, thoughts and feelings. Together we will identify a series of goals to help you address your issues. You have the right to refuse anything that I suggest. We will openly discuss your treatment plan and interventions.

The nature of our treatment focuses on Christian counseling. Counseling seeks to identify issues that are affecting your life and then develop strategies for meaningful change. Christian counseling integrates professional counseling with applied psychology and practical theology. Christian counseling provides a faith based approach to resolve thinking/cognitive, emotional and relationship issues. This approach accepts the Bible as our authority base. I depend on the indwelling power of the Holy Spirit as our source of strength and insight into our lives. Although people from a variety of backgrounds and belief systems may seek our services,

PROCESS OF THE THERAPY/COUSELING AND ASSESSMENT (CONT)

I believe that Christian counseling is universal and can be applied to all people regardless of background and circumstance.

TERMINATION

After identifying the issues that brought you to counseling, I will assess whether I can be of benefit to you. If it is determined that I am unable to help you achieve your goals, I will suggest to you other treatment options. If you request it and authorize it in writing I would be willing to speak to the therapist of your choice to assist with the transition. You have the right to terminate counseling at any time. Otherwise, counseling typically concludes when a client believes that they have received the benefit and attained the goals they were seeking.

COMPLAINTS

If you're unhappy with what's happening in counseling, I hope you will talk about it with me so that I can respond to your concerns. I will take such criticism seriously, and with care and respect. If you believe that I've been unwilling to listen and respond, or that I have behaved unethically, you can complain about my behavior to the Department of State and Professional Compliance Office, PO Box 2649, 2601 North Third Street, Harrisburg, PA 17105-2649. You are free to discuss your treatment with me and with anyone you like; you are under no obligation to maintain confidentiality about what I do that you don't like, since you are the person who has the right to decide what you want kept confidential.

I, _____, have read the above Consent to Treatment. I have had an opportunity to discuss any questions and I agree to meeting with Carla Smith.

Signature of Client (or person acting for client)

Date

Printed Name

Relationship to client

Signature of Therapist

Date