

Wabash Friends
**COUNSELING
CENTER**

Informed Consent and Information Form

Name (client): _____ Soc. Sec. # _____
Date of Birth: _____ Race: _____ Email: _____
Occupation/Employer: _____
Spouse (if applicable): _____ Soc. Sec. # _____
Date of Birth: _____ Race: _____ Email: _____
Occupation/Employer: _____
Address: _____ City: _____ Zip: _____
Phone: (home) _____; (work) _____ ext. _____; (cell) _____
Married _____ Separated _____ Divorced _____ Widowed _____ Never Married _____

If client is a minor:
Biological father/step father: _____ Phone: _____
Biological mother/step mother: _____ Phone: _____

Children/Siblings names & ages: _____
Who referred you? _____
Family Physician _____ Phone: _____
Address: _____

Initials

_____ I understand I have made a voluntary choice to be involved in counseling provided by a mental health professional as defined by Indiana law. I understand counseling is a cooperative effort between myself and my counselor and I agree to keep him/her aware of my needs, resolving any difficulties which may arise. I am free to terminate counseling at any time.

_____ I understand I am consenting only to those mental health services that my counselor is qualified to provide within the scope of the professional (or his/her supervisor's) license, certification, and training he/ she has obtained.

_____ I understand my treatment will be kept in confidence. Release of information will only occur by my informed, signed, and witnessed consent. The only exceptions to this are those required/allowed by law, including but not limited to perpetration of sexual abuse, danger to self or others, and treatment of minors. (Discuss with your therapist questions you might have.)

_____ I authorize the Wabash Friends Counseling Center (WFCC) to release necessary medical information to appropriate third parties for reimbursement purposes and/or to persons authorized to conduct service utilization reviews.

_____ I authorize my counselor to contact my Primary Care Physician to coordinate services.

_____ I understand and agree: I am personally and fully responsible to pay for all services rendered; if I have insurance with a carrier which has a contract with the Wabash Friends Counseling Center, WFCC will file claims on my behalf, and I agree to pay the balance of any and all services not deemed "reasonable and necessary" by my carrier, as well as any co-payments or other payments according to the terms of the applicable carrier's contract. I agree to pay in full any non-covered services which are not covered by my insurance carrier.

_____ I understand that I am responsible to give at least 24 hour notice when canceling appointments and that I am responsible to pay for my appointment in full if 24 hour notice is not given. Missed appointments without cancellation notice cannot be billed to insurance.

Client(s) Signature: _____ Date: _____
_____ Date: _____

Parent/Guardian (if client is minor): _____ Date: _____
Counselor's Signature: _____ Date: _____