



## ***Our Space***

**Family Mental Health Counseling, PLLC**  
Susan R. Grande, Director and Principal Therapist  
2725 Harway Avenue, Brooklyn, NY 11214  
(718) 333-0321 [www.ourspacefamilycounseling.com](http://www.ourspacefamilycounseling.com)

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Text message enabled: Yes/\_/ No/\_/

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

### **INFORMED CONSENT FOR THERAPY SERVICES**

*Our Space Family Mental Health Counseling PLLC* is an independent counseling practice designed to help adults, children and families. *Our Space* provides assessments, individual counseling for adults, children, couples, and families, and therapeutic group sessions. Referrals to other resources may be recommended. Services are provided by licensed clinicians, graduate level interns, and other certified counseling professionals, who are practicing under clinical supervision and/or New York State Permits.

*Our Space* is licensed to provide *telehealth counseling* in the states of New York, New Jersey, Pennsylvania, Delaware and Florida, and wherever a reciprocity agreement exists with New York State. As an addendum to this “Informed Consent” form, please download, read, sign and return the “*Informed Consent – Counseling via Telehealth*” form located in the [Client Resources/Forms section](#) of our web page. This addendum is for those not attending in-person counseling.

At *Our Space Family Mental Health Counseling PLLC*, we are committed to your privacy. Federal HIPAA guidelines are strictly followed. For more information about the HIPAA Law, please visit <https://www.hhs.gov/sites/default/files/privacysummary.pdf>.

### **PSYCHOLOGICAL SERVICES POLICIES AND PROCEDURES**

As a client, it is important to understand the rights and responsibilities of both the therapist and the client, as well as the therapeutic process. Both are outlined below:

- Some benefits of therapy are significant reductions in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness, increased skills for managing stress and resolutions of problems.
- It is important to be made aware that the therapeutic process can bring out feelings of sadness, guilt, anxiety, anger and frustration.
- The healing process consists of an evaluation of your needs, the creation of treatment goals and a treatment plan.

- You will be charged for all scheduled appointments, including those that are cancelled or broken without 24 hours' notice. Please read the "Cancellation Policy" form on page 4.
- *Our Space* is NOT a participating provider for insurance plans. Our services are to be paid out-of-pocket by cash, check, credit/debit card or electronic fund transfer, such as Zelle® or PayPal®. We will provide you with a receipt of payment, which may be submitted to your insurance company for reimbursement depending on your insurance company's reimbursement policy.
- Under normal circumstances, all information you discuss or share with the counselor will be held in strict confidence. However, you should be aware that there are some situations that your counselor or *Our Space Family Mental Health Counseling PLLC* may be required by law to report information to the proper authorities without your permission or knowledge. These situations include, but may not be limited to:
  - indication of bodily harm to others
  - involvement in a felony
  - suicidal intentions
  - the suspicion of child abuse or neglect or elder abuse or neglect.
- This contract is an agreement that no client or associated parties shall attempt to request from *Our Space* and its counselors any records or testimony for deposition or court proceedings of any kind for any reason. All parties acknowledge that the process and effectiveness of psychotherapy is dependent on trust and openness during therapy sessions. All parties must be made aware that if the services of a psychotherapist are requested, information given to the psychotherapist during the therapeutic process will not be used for any legal purposes or against any other parties in any legal setting of any kind.  
*Please note: An exception to this non-disclosure statement occurs when a subpoena is issued by a Court of Law and duly served.*
- Your counselor may be contacted by phone, text or email if you need to talk outside of a scheduled session. In addition, you may leave a message on our confidential voicemail and the counselor will get back to you at the earliest convenience. If it is an emergency, go to your local hospital or call 911. Speak to the mental health professional on duty.
- If you are unhappy with therapy, you are encouraged to speak to us about your concerns. We take all situations seriously and handle each with respect and care. You may request a referral to another therapist or to end therapy at any time.

## **LIMITS OF CONFIDENTIALITY**

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The types of information that may be released with your permission include, but are not limited to:

- Types of service
- Dates/times of service
- Diagnosis
- Treatment plan
- Description of the presenting problem
- Progress of therapy
- Summaries

The following is a list of exceptions that do not require your permission:

- **Duty to Warn and Protect:** If you disclose a plan or threat to harm yourself, the therapist must attempt to notify appropriate family and legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the intended victim and notify legal authorities.
- **Abuse of Children and Vulnerable Adults:** If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, physically or mentally disabled), the therapist must report this information to the appropriate agency and/or legal authorities.
- **Prenatal Exposure to Controlled Substances:** Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.
- **Minors/Guardianship:** Custodial parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

## CONSENT

**Client/Caregiver:** *I have been informed of the nature and purposes of services provided, and that my consent can be revoked orally or in writing prior to, and/or during the treatment process. No guarantee or assurance has been made to me as to any of the results that may be obtained from the counseling and/or referral services provided. I agree to hold harmless my professional counselor for any unpleasant or unexpected effects which may arise from treatment. I have read and fully understand the informed consent for services at Our Space Family Mental Health Counseling PLLC.*

### PLEASE PRINT YOUR NAME / THEN SIGN YOUR NAME

\_\_\_\_\_  
Client Name / Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name/Signature of Parent/Guardian/Foster Parent if client is under 18 years old; Name/Signature of Legal Guardian if client is a ward 18 years old or older.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name / Signature of Witness/Therapist/Mental Health Professional

\_\_\_\_\_  
Date

\*\*\*\*\*End of Informed Consent Form\*\*\*\*\*

**Please read and sign Cancellation Policy form on the next page.**

## CANCELLATION POLICY

If you are unable to attend an appointment, we request that you provide at least 24-hours' notice in advance to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency. For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or for scheduled appointment that is missed without any contact from you, your guardian or a trusted adult, a bill for the full session fee will be added to your account. We appreciate your help in keeping the office schedule running in a timely and efficient manner.

**Client/Caregiver: *I have read and understand the Cancellation Policy.***

\_\_\_\_\_  
Client Name / Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name/Signature of Parent/Guardian/Foster Parent if client is under 18 years old.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name/Signature of Legal Guardian if client is a ward 18 years old or older

\_\_\_\_\_  
Date