

## Client Information and Consent to Treatment

Thank you for choosing Dr. Kristina Welker PsyD, MC, LAC for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with the procedures and policies of my practice, I am providing the following information.

**Appointment:** If you need to cancel an appointment, **a minimum of 24-HOUR NOTICE IS REQUIRED; otherwise you will be charged for the appointment.** In the evenings and weekends, you may leave a message on my voice mail. Unless I have an emergency, I will do my best to be punctual for your appointment. I ask that you be punctual as well. If you are late, you will receive the remainder of your scheduled time. This is necessary so I can see the following clients at their scheduled times. In order to keep my files up to date, after a 90-day lapse in service, I will assume you no longer desire counseling services. I will attempt to contact you by phone regarding this lapse. You may call at any time to discuss resuming your counseling services.

**Emergencies:** For any psychiatric crisis, please call the crisis line at (602) 222-9444. You may also leave me a message on my voice mail at (602) 448-7444. Phone consultation fees will apply for all calls.

**Financial Responsibility:** You are fully responsible for all services rendered. Full payment is expected at time of service **at the beginning of each session.** There will be a \$20.00 fee for payments returned as non-sufficient or non-payable.

**Confidentiality:** Your patient records will be confidential. To comply with state and federal laws regarding patient confidentiality, your records will not be released without the properly executed written consent. Everything about your care will be held in strictest confidence (with the exception of those situations which I am required by law to report, including imminent danger to yourself or others, suspected child or elder abuse). If you chose to have me inform a third party of your counseling progress, it will be necessary to complete a "Release of Information" form that will be kept in your file. You may request a copy of your records via a signed release of information. Prior to the release of these records I will review the contents with you.

**Counseling Services:** I have chosen to receive counseling services from Dr. Kristina Welker for the purpose of my own personal enrichment. These services may include individual, couples or family counseling. This also includes my participation in my treatment planning and assessment of my progress. My choice has been voluntary and I understand that I may terminate therapy at any time. Because counseling is a cooperative effort between my therapist and me, I will work in a cooperative manner to resolve my issues. I understand that during the course of my counseling, material will be discussed which may be upsetting, but this may be necessary to help me resolve my problems. If at any point during treatment my therapist determines that her services are no longer appropriate, I understand that she will refer me to another therapist. I also understand that it is my choice as to whether or not I pursue those referrals or seek alternative treatment.

**Counseling Theory:** As a therapist, I believe that all individuals, if so motivated, are capable of change. I believe that the past influences present behaviors and an understanding of this helps individuals to change current behaviors. I believe that thoughts and attitudes play a key role in how individuals feel and behave and by addressing the way they think...individuals can change. I believe that God plays an integral role in change and I will incorporate this in my counseling practices according to each client's comfort level. I am a Christian and I utilize Christian values and principles. However, I will respect and honor my client's beliefs and value systems at all times.

**Signed:**

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