Dear Friend,

I am glad you are here and taking this courageous and brave step to start counseling. Please take time to read the below Counseling Agreement regarding your counseling experience with me, Sabrina Hickel, at SRH Counseling.

I understand that the counseling that I am receiving will be from Sabrina Hickel, a Licensed Professional Counselor (LPC).
_____ (Please initial)

If audio or video recordings are made, I will be asked for permission and informed which sessions are being recorded. All written or otherwise recorded notes from the counseling sessions will be kept in a secure place during my time in counseling and for seven years thereafter.
_____ (Please initial)

There will be no communication about my situation or my family to any third party without my permission. However, in the rare situation where my counselor believes that I may be a danger to others or myself, confidentiality may be broken in order to take whatever precautionary action necessary. Also, any physical or sexual abuse of a child or elder revealed in session must be reported.
_____ (Please initial)

In a rare situation, if my counselor is subpoenaed in relation to a lawsuit involving me, confidentiality may be broken.
_____ (Please initial)

If my counselor believes that I will be better served by referral, she will not hesitate to discuss this with me and assist with the referral.
_____ (Please initial)

Any disputes or modifications of this agreement shall be negotiated directly between the parties; if negotiations are not satisfactory, then the parties agree to mediate any differences with a mutually acceptable third-party mediator. I agree to indemnify and hold harmless Sabrina Hickel and SRH Counseling, its agents, servants, or employees from any claim for damages of any nature arising out of, or allegedly due to, any counseling, instruction, or advice rendered.
_____ (Please initial)

I understand that there will be a full session charge for any sessions not canceled with 24 hours-notice. In the case of emergencies, I understand I can ask my counselor to waive this fee.
_____ (Please initial)

(over)

I understand that to protect my privacy and confidentiality, as well as provide effective therapy, my counselor does not use email, and only uses electronic communication for scheduling purposes. I also understand my counselor, for these same reasons, does not "friend" clients on social media sites until two years after therapy is terminated.

_____ (Please initial)

I understand that I have the right to look at or get copies of my file and health information. I may request that SRH Counseling provide copies of my file, or an alternative form unless it cannot be done practically. I understand I must make a request in writing to obtain access to my health information. I understand that I may retain a form to request access by asking my counselor, Sabrina Hickel. I understand SRH Counseling will work to respond to my request within 10 business days. I understand that if I feel that my privacy protections have been violated, I have the right to file a complaint with the Department of Health & Human Services, Office of Civil Rights. I understand I can request the mailing address to file my complaint with the U.S. Department of Health & Human Services upon written request or I can visit their website at: http://www.hhs.gov/ocr/office/file/index.html.

_____ (Please initial)

I have read, discussed and fully understand the terms of this contract and agree to receive services for myself and/or my child/children under these conditions.

Signed: _____ Date: _____
(Client Signature)

Please print name: _____

Signed: _____ Date: _____
(Client Signature)

Please print name: _____

Signed: _____ Date: _____
(Parent/Guardian Signature)

Please print name: _____

Signed: _____ Date: _____
(Counselor Signature)

Please print name: Sabrina Hickel, LPC