INFORMED CONSENT—GROUP COUNSELING

Welcome to Girl Talk

Group counseling can be a powerful and valuable venue for healing and growth. It is my desire that your child reaps all the benefits group has to offer. To help this occur, groups are structured to include the following elements:

- A safe environment in which your child is able to feel respected and valued as she works
- An understanding of group goals and group norms
- An investment by both the facilitator and members of the group to produce a consistent group experience

A SAFE ENVIRONMENT
A safe environment is created and maintained by both the facilitator of a group and its members. Primary ingredients are mutual respect and a chance to create trust. Another primary ingredient for a safe environment has to do with confidentiality. I am bound by law to maintain confidentiality, as group members are bound by honor to keep what is said in the group in the group. I realize that your child may want to share what she is learning about herself in group with a significant other. This is fine as long as she remembers NOT to talk about how events unfold in group or in any other way compromise the confidentiality of other group members.

I will ask you to sign a release form if you would like me to talk with her individual therapist. This is a safeguard for the member which allows consultation between her group leader and her individual therapist should the need arise. This also provides extra support should a difficult issue come up in group that may need more individual attention.

LIMITS OF CONFIDENTIALITY:
- If a member is a threat to herself or others (showing suicidal or homicidal intent), I may need to report her statements and/or behaviors to family, her therapist, or other appropriate mental health or law enforcement professionals in order to keep her and others safe.
- There are broad ranges of events that are reportable under child protection statues. Physical or sexual abuse of a child will be reported to Child Protective Services. When the victim of child abuse is over age 18, reporting is not mandatory unless there are minors still living with the abuser, who may be in danger. Elder abuse is also required to be reported to the appropriate authorities.
- If a court of law orders a subpoena of case records or testimony, I will first assert “privilege” (which is your right to deny the release of your records although this is not available in all states for group discussions). I will release records if a court denies the assertion of privilege and orders the release of records. Records may also be released with your written permission.
Records will include only your child’s personal progress in group—not information about other group members.
- I may consult with other professionals regarding group interactions. This allows a freedom to gain other perspectives and ideas concerning how best to help your child reach her goals in group. No identifying information is shared in such consultations unless a release has been obtained from you.

OTHER SAFETY FACTORS:
- Members of a group may not use drugs or alcohol before or during group
- Members of a group should not engage in discussion of group issues outside of group
- Members of group should remember that keeping confidentiality allows for an environment where trust can be built and all members may benefit from the group experience
- I will monitor discussions and maintain a respectful environment to keep safety and trust a priority

ATTENDANCE
Your child’s presence in group is highly important. A group dynamic is formed that helps create an environment for growth and change. If your child is absent from the group, the dynamic suffers and affects the experience of your child and other members of the group. Therefore, I would ask that you make this commitment a top priority for the duration of the group.
It is understood that occasionally an emergency may occur that will prevent your child from attending group. If you are faced with an emergency or sudden illness, please contact me before group begins and let me know she will not be present.
Because it usually takes several group sessions for clients to "settle in" and receive the full benefits a therapy group provides, I ask incoming members to make a **10-week commitment** when they join a group. I also ask members to give a 3 week notice when they decide to leave a group. I ask this because **each member of a group is important**—your child’s presence and her absence impacts members and me--and I want to allow time for members to process when members choose to leave.

WHAT TO EXPECT
Group time consists of both teaching and processing time. Processing may revolve around an issue one member of the group is working on with time for structured feedback and reactions by other members of the group. At times the group may focus on a topic with all members verbally participating. In either case, the group dynamic offers a place where your child can experience support, give support, understand more clearly how she relates to others, and examine her own beliefs about herself, her relationships, and the world around her. These dynamics provide a very powerful environment for change.
Remember, the more your child gives of herself during the sessions, the more she will receive. The more honest and open she is, the more she will allow for insight and growth.

FEES
The fee for this group is $60 per 60 minute session. If you would like to pay for all ten sessions in advance, the fee is discounted to $550.
Consent to Treatment

I voluntarily agree to receive counseling services from Cory Montfort, and authorize her to provide such care, treatment or services, as are considered necessary and advisable. By signing this Group Information and Consent form, I acknowledge that I have both carefully read and understand all the terms and information contained herein. I have asked and sought clarification on any unclear terms or concepts at this time. I also acknowledge that I agree to all of the terms in this form and have received a copy.

Please Initial:

__________ You affirm that you have been informed of the likely benefits and material risks of treatment, and that you have been informed of some of the strictures and/or responsibilities of this counseling treatment. This disclosure was understood by you and enabled you to make an informed voluntary consent to this treatment. It is understood that you may revoke this consent at any time.

__________ You are financially responsible for payment in full of all services rendered through Cory Montfort, including assessment services, session fees, phone consults, email responses, court/legal fees assessed, reports/letters written, and the like. Should you get behind in your financial responsibilities, Cory Montfort has the right to withhold further treatment until payment for prior services has been received.

__________ You authorize the release of any information necessary to process any insurance claims and authorize payment of insurance benefits to Cory Montfort, LPC.

__________ You authorize the release of any information necessary to coordinate treatment with medical professionals, therapists, hospitals, insurance or managed care companies involved with this case.

__________ You represent that you have the legal authority to obtain counseling for any minor children treated.

Client Signature _____________________________  Date _______________________

Client Signature _____________________________  Date _______________________

Child’s Name     _____________________________  DOB _______________________ 

I certify that I am the (circle one) father/mother/legal guardian of the above named child, and I hereby give my authorization and consent for the above named child to receive outpatient assessment/therapy from Cory Montfort.

Signature ______________________________________ Date ______________________

Counselor Signature ______________________________ Date ______________________
Credit Card Authorization Agreement

By signing this agreement, I am authorizing Cory Montfort, LPC to bill my credit card for all professional services rendered to the “Client” that are not paid at the time of service, or for situations which fall under the late cancellation policy listed below. I agree that I will not dispute those charges (“charge back”), which may include, but are not limited to:

☒ The full fee for a session if the client does not show for an appointment and has not cancelled or rescheduled as outlined in the cancellation policy.

☒ Telephone contact in excess of that usually associated with services, prorated at our regular hourly rate, with prior notice given before any charges are incurred, this may include phone contact in excess of 15 min.

☒ Deductibles, excluded services, insurance payments made to someone other than the provider, or other charges that have not been directly reimbursed by insurance.

☒ Checks that are returned will incur the check amount and additional $35 fee.

If you have questions or concerns regarding any part of this fee structure or billing/payment policies, please discuss these with me as soon as possible. This form will be securely stored in client’s clinical file and updated upon request at any time.

Credit Card Type (check one): ☐Visa ☐MasterCard ☐AMEX ☐Discover
Number: ___________________________________________ Expiration Date: ________________
Name as Printed on Card: ________________________________
Verification/Security Code (3-digit code on back of card by signature line): ________________
Billing Address: ______________________________________
City: ____________________________ State: ____ ZIP: ____________
Signature of Payor: ______________________________________
Print Name of Payor: ____________________________ Date: ________________

Please Initial each of the following:

____ Charge for sessions cancelled with less than 24 hours notice and for appointments I miss without notice which will be billed to my card for this purpose.
____ I understand my card will be charged for returned checks for amount of check plus $35.
____ Balances of charges not paid within 7 days of service, or not paid by insurance, will be charged on credit card.
____ I will not dispute charges for sessions I have received, appointments I have missed with less than 24 hrs. notice, or charges due to bounced checks.

_________________________________ (signature) ____________ (date)