**Blue Stone Counseling LLC**
10040 N. Port Washington Rd.
Mequon, WI 53092
Phone: 414-375-9273
email: susie@bluestonecounselingllc.com

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I**MPORTANT INFORMATION AND CLIENT CONSENT**: Please read and sign as indicated stating you have read and understand the information below.

**CLIENT/THERAPIST RELATIONSHIP**: You and your therapist have a professional relationship existing exclusively for therapeutic treatment. The relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

**AVAILABLE SERVICES**: Blue Stone Counseling LLC offers individual adult and adolescent counseling for mental wellness primarily focused on treating anxiety and depression. Blue Stone is dedicated to serving individuals in a discreet and peaceful environment which enhances mental wellness.

**COUNSELING**: I provide short term counseling by developing a 90 day treatment plan which serves to address presenting concerns and utilizes counseling methods for achieving wellness goals. This treatment plan will be revised every 90 days with the intent to provide solution focused and strength based therapy. Clients are offered personalized attention and Blue Stone Counseling strives to refer individuals to other healing modalities that will enrich their lives and expand the repertoire of tools available for improved coping and stress management. Effective counseling is founded on mutual understanding, respect, and good rapport between client and counselor. It is my intent to convey the policies and procedures used in my practice and I will be pleased to discuss any concerns or questions you may have regarding treatment.

**RISKS and BENEFITS**: As with any treatment there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt and sadness. The benefits of counseling include improved personal relationships, reduced feelings of emotional distress and improved strategies for coping, problem solving, distress tolerance resulting in greater emotional and mental wellness. Blue Stone Counseling operates in consultation with a licensed psychiatrist, but no medications are prescribed. If at any time you feel that I am not a good fit for you, I will be happy to discuss alternative options or to refer you to a different therapist. Clients retain the right to withdraw consent to treatment at any time by expressing this in writing to the provider as well as to be referred to another provider if so desired.

**APPOINTMENTS**: Appointments will be scheduled for 1 hour in length. Your appointment is expressly reserved for you, and as a courtesy I provide email or telephone reminders to you the day before your appointment. If you must cancel or reschedule your appointment, I require that you contact me at least 24 hours in advance so that your appointment time can be used by another client. Please note the fee for failing to provide 24 hours advance cancellation notice:

***Blue Stone Counseling does not accept insurance.**
***Payment is expected at time of service.**

**FEE SCHEDULE**:

| | |
|---|---|
| **Intake and Evaluation Session or EMDR (90 minutes)** | **$150.00** |
| **Regular Office Visit (1 hour)** | **$110.00** |
| **Missed Appointment fee** | **$25.00** |

**EMERGENCIES**: If you have a concern you may call the office phone number and my cell phone (262) 751-9564 and I will return your call as soon as possible. For serious mental health emergencies you may contact the COPE hotline at (262) 377-COPE, follow your safety plan, or go to your local emergency room. If you have a personal concern that requires immediate attention but is not at a level of requiring emergent care, please contact me regarding the nature and urgency of the circumstance. I will make every effort to schedule you as soon as possible or to explore other options. I will make every effort to respond to messages left on the office phone in a timely manner. If an emergency arises after office hours or on weekends, case by case phone consultation will offered via contact by cellphone.

**CONFIDENTIALITY**: I practice all ethical standards prescribed by state and federal law for maintaining client therapist confidentiality. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential. No information will be released without a client's written consent unless mandated by law. Possible exceptions to confidentiality are listed on the attached page 2 of the Wisconsin Notice Form for Mental Health Providers' Policies and Practices to Protect Privacy of Your Health Information.

**EMDR THERAPY**: Eye Movement Desensitization and Reprocessing (EMDR) therapy is an extensively researched, effective psychotherapy method proven to help people recover from trauma and other distressing life experiences, including PTSD, anxiety, depression, and panic disorders. EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. EMDR therapy focuses on changing the emotions, thoughts, or behaviors resulting from the distressing issue and allows the brain to resume its natural healing process.

**DUTY TO WARN/DUTY TO PROTECT (SAFETY PLAN)**

If my counselor, Susan K. Miller, believes that I (or my child if my child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent for her to contact the person who is in a position to prevent harm to me or to another, including but not limited to, the person in danger. I also give consent for Susan K. Miller, or her supervisors, to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate.

| NAME(s)/ADDRESS | TELEPHONE NUMBERS |
|---|---|
| _____ | _____ |

**WISCONSIN HEALTH PRIVACY PRACTICES REVIEW (ATTACHMENT)**:

I have received a copy of the Joint Notice of Privacy Practices for Blue Stone Counseling LLC. I understand the information presented.

| _____ | _____ |
|---|---|
| CLIENT SIGNATURE | DATE |
| _____ | _____ |
| CLIENT PARENT OR GUARDIAN (IF MINOR) | DATE |

**CLIENTS RIGHTS AND GRIEVANCE PROCEDURE FOR OUTPATIENT MENTAL HEALTH (ATTACHMENT)**:

You will provided with a copy of our Grievance Procedure. This details those individuals or organization with whom you can file a complaint in the event that you are concerned about your care or treatment.

Clients may also express their concerns in writing to the American Counseling Association Ethics Committee which oversees its member's conduct at **Ethics Committee, ACA Headquarters, 5999 Stevenson Ave., Alexandria, VA 22304**. Please mark communication as "CONFIDENTIAL".

I have received a copy of the Clients Rights and Grievance Procedure for Community Services from Blue Stone Counseling LLC. I understand the information presented.

| _____ | _____ |
|---|---|
| CLIENT SIGNATURE | DATE |
| _____ | _____ |
| CLIENT PARENT OR GUARDIAN (IF MINOR) | DATE |

**CONSENT TO TREATMENT:**

I give my consent to the proposed treatment and services as detailed above. It is further understood that this consent shall remain in force for no longer than 15 months from the date noted below. It is further understood that I may withdraw my consent to treatment at any time, but that this consent is assumed to continue as long as I am a client of Blue Stone Counseling LLC.

If I am court ordered to treatment I realize that some of my rights may be affected in terms of consent to treatment. If that is the case, I agree to discuss the issues and consequences fully with my therapist.

I have been provided, both orally and in writing, my rights, in accordance with Wisconsin Statutes s.51.61 (1)(a) and State of Wisconsin DHS 94.

I agree by signing that we have reviewed the following:

_____ Client' Rights and the Grievance Procedure

_____ Wisconsin Notice for Privacy of Health Information Act

_____ Financial Responsibility and rates for services

_____ Cancellation/No Show Policy

_____ Services provided and after hours and crisis options

_____ Limits of Confidentiality

_____ For Minors: We have reviewed policies and procedures for confidentiality and limits of confidentiality between parents or guardians, provider and client.

_____ _____

**CLIENT SIGNATURE** **DATE**

_____ _____

**CLIENT PARENT OR GUARDIAN (IF MINOR)** **DATE**

_____ _____

**Susan K. Miller, M.S. LPC NCC** **DATE**
**BLUE STONE COUNSELING**

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COUNSELING