



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

## Motivated Wellness Solutions Intake Paperwork

### Demographic Information

Client name: \_\_\_\_\_ Date: \_\_\_\_\_

Marital Status: M | S | D | W    M | F | Other    DOB: \_\_\_\_\_

Email: \_\_\_\_\_

Client Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

May we leave a message on your phone?            Yes            No

### Emergency contact/Guardian information

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Insurance Information

Full Name of Policy Holder: \_\_\_\_\_

DOB of Policy Holder: \_\_\_\_\_                      Phone number of Policy Holder: \_\_\_\_\_

Address of Policy Holder: \_\_\_\_\_

Client Relationship to Policy Holder: \_\_\_\_\_

Group Number: \_\_\_\_\_                      Member or Subscriber Number: \_\_\_\_\_

Plan Name: \_\_\_\_\_                      SSN of Policy Holder: \_\_\_\_\_

Name of Insurance Company as Shown on Card: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

## Credit Card on File Agreement

We have implemented a policy agreement which enables you to maintain your credit card information securely on file with Motivated Wellness Solutions, LLC. Payments are due at the time of service. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed. In providing us with your credit card information you are giving Motivated Wellness Solutions, LLC permission to automatically charge your credit card on file for your (or any other client(s) you have listed on this form) co-pays/co-insurance, outstanding balances, services, and/or products.

**Co-Pay/Co-Insurance:** Co-pays and co-insurance are due at the time of service. You may still choose to make your payment with a different card from the card on file.

**Outstanding Balance:** If your insurance provider has paid their portion of your bill (or any other client(s) you have listed on this form) and there is still an outstanding balance owed, Motivated Wellness Solutions, LLC will notify you via phone, email, and/or mail. If the balance is not paid in full within 5 days of the notice, at that time, any balance owed will be charged to your credit card. A copy of the charge will be emailed and/or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

**Services and Products:** Self pay services and other fees are due at the time of service.

This card will only be authorized for the use of the credit card holder or any other person(s) listed below by the credit card holder. **This agreement will expire upon termination of services and settlement of the final balance.** The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

Visa	MasterCard	Discover	American Express	Other: _____
Credit Card Holder's Name: _____ (Please Print)				
Credit Card #: _____		Expiration Date: _____		
Billing Zip Code: _____		CVV\$ (on back of card): _____		
Please fill out the information below for any other person(s) you authorize this credit card for: If NO OTHERS ALLOWED, strike through and initial.				
Client Full Name: _____		DOB: __/__/__		
Client Full Name: _____		DOB: __/__/__		
Client Full Name: _____		DOB: __/__/__		

Credit Card Holder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

I understand that by signing above, I am authorizing Motivated Wellness Solutions, LLC, LLC to charge my card in the manner indicated by my initials above. These balances may include out of pocket payments, so show or late cancel fees. I understand that Motivated Wellness Solutions, LLC, will mail or email me a printed statement as proof of payment.

By signing below, I (we) have read, understood, and agreed to the Statement of Informed Consent for Credit Card on File:

\_\_\_\_\_  
Client Name (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Name (Signature)

\_\_\_\_\_  
Date



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

## **Outpatient Service Contract**

Welcome to Motivated Wellness Solutions, LLC,. Since this is your first visit, we hope what is written here can answer some of your questions as you seek therapy. Please let us know if you want clarification on any of the topics discussed in this Outpatient Services Contract, or if you have any questions that are not addressed here. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

### **Psychotherapy Services**

We provide psychotherapy services for adolescents, adults, couples, and families. The first appointment(s) serves as an intake appointment. We will want to hear about the difficulties that led to you making an appointment, goals for therapy, and general information about yourself and your current life situation. By the end of this first appointment, we will give you some initial recommendations on what we think will help. If we do not think we are able to best assist you, we will give you names of other professionals who we believe would work well with your issues. If you do not agree with our treatment recommendations or do not think our personality styles will be a good match for you, let us know and we will do our best to suggest a different therapist who may be a better fit or make an outside referral.

If you and your therapist decide to work together in therapy, you will collaborate on a treatment plan that incorporates effective strategies to help with whatever difficulties you are hoping to reduce in therapy. Sometimes more than one approach is helpful. Individual, couples, and family therapy sessions last 45-60 minutes (depending on your need) unless otherwise arranged. Oftentimes, sessions are set for once each week, but this varies based on what seems most appropriate for your individual needs.

Therapy can be extremely helpful and fulfilling, and it takes work both in and out of sessions to be most effective. It requires active involvement, honesty, and openness to change thoughts, emotional reactions and/or behaviors. There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved communication, and stability in relationships, and lessening of distress. Some potential risks include increased uncomfortable emotions as you self-explore, and changes in dynamics or communication with significant people in your life. Sometimes couples that come for therapy choose to end their relationships. Although there are many benefits to therapy, there is no guarantee of positive or intended results. If during your work together with your therapist, noncompliance with treatment recommendations becomes an issue, we will make an effort to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance may necessitate termination of therapy service. We encourage you to discuss any concerns you have about our work together directly so that we can address it in a timely manner. Other factors that may result in termination of therapy include, but are not limited to, violence or threats toward us, or refusal to pay for services after a reasonable time and attempts to resolve the issue.

Deciding when therapy is complete is meant to be a mutual decision, and we will discuss how to know when therapy is nearing completion. Sometimes people begin to schedule less frequently to gradually end therapy. Others feel ready to end therapy without a phasing out period. We may at times seek consultation with other therapists to ensure we are helping you in the most effective manner. We will give information only to the extent necessary, and we make every effort to avoid revealing the identity of clients. The consultant is also under a legal and ethical duty to keep the information confidential.

### **Personal Records**



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

Both law and the standards of our profession require that we keep appropriate treatment records. If we receive a request for information about you, you must authorize in writing that you agree that the requested information is released.

### **Confidentiality**

In general, law protects the confidentiality of all communications between a client and a mental health clinician, and we can only release information to others with your written permission. However, there are several exceptions, which are indicated below. More information is provided about this in your HIPAA statement.

In judicial proceedings, if a judge orders the records released, we must release the records. In addition, we are ethically and legally required to take action to protect others from harm even if taking this action means we reveal information about you. For example, if we believe a child, elderly person or disabled person is being abused or neglected, we are mandated to report this to the appropriate state agency. If we believe a client is threatening serious harm to another person or property, we must take protective action (through notifying the potential victim, the police, and/or facilitating hospitalization of my client). If we believe a client is a serious threat to harming him/herself, we must take protective action (arranging hospitalization, contacting family/ significant others for notification, and/ or contacting the police). We would make reasonable effort to discuss any need to disclose confidential information about you, and we are happy to answer any questions you have about the exceptions to confidentiality.

### **Minors**

We do not currently work with individuals under the age of 14 years old. If you are between the ages of 14 and 18, the law may provide your parents the right to examine your treatment records if after being informed of your parents' request to examine your records, you do not object or your therapist does not find that there are compelling reasons for denying the access to the records. Notwithstanding the above, your parents are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what is prepared to discuss.

### **Court Related Services**

We do not provide or perform evaluations for custody, visitation, emotional support animal letters, medical exemption letters or other forensic matters. Additionally, we do not provide disability, FMLA, accommodation letters, or other similar letters to new clients, you must be a well-established client to receive any of the previously listed letters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation, or fitness of a parent in any legal matters or administrative proceedings.

### **Complaints**

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your criticism seriously, openly, and respond respectfully.

### **Questions**

If during your therapy, you have any questions about the nature of your therapy or about your billing statement, please ask.



Motivated Wellness Solutions, LLC  
 Clinical Counseling, Consulting, and Coaching  
 Phone: 740.233.6357  
 Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

## A Final Word

The counseling relationship is a very personal and individualized partnership. We want to know what you find helpful and what, if anything, may be getting in the way. We want you to feel free to share with us what we can do to help.

### RIGHTS AND RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS	YOUR CHOICES	OUR USES AND DISCLOSURES
You have the right to:	You have some choices in the way that we use and share information as we:	We may use and share your information as we:
<ul style="list-style-type: none"> <li>Get a copy of your paper or electronic medical record</li> <li>Correct your paper or electronic medical record</li> <li>Request confidential communication</li> <li>Ask us to limit the information we share</li> <li>Get a list of those with whom we've shared your information</li> <li>Get a copy of this privacy notice</li> <li>Choose someone to act for you</li> <li>File a complaint if you believe your privacy rights have been violated</li> </ul>	<ul style="list-style-type: none"> <li>Tell family and friends about your condition</li> <li>Provide disaster relief</li> <li>Include you in a hospital directory</li> <li>Provide mental health care</li> <li>Market our services and sell your information</li> <li>Raise funds</li> </ul>	<ul style="list-style-type: none"> <li>Treat you</li> <li>Run our organization</li> <li>Bill for your services</li> <li>Help with public health and safety issues</li> <li>Do research</li> <li>Comply with the law</li> <li>Respond to organ and tissue donation requests</li> <li>Work with a medical examiner or funeral director</li> <li>Address workers' compensation, law enforcement, and other government requests</li> <li>Respond to lawsuits and legal actions</li> </ul>

#### 1. Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

##### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

##### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

##### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

##### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

##### Get a list of those with whom we have shared information



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

#### **0. Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

#### **0. Our Uses and Disclosures**

##### **1. How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

#### ***How else can we use or share your health information?***

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### **Do research**

We can use or share your information for health research.

#### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

#### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

#### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual die.

#### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

#### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

#### **0. Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

#### **Changes to the Terms of this Notice**

**0. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.**

#### **Outpatient Services Contract**

Please ask before signing below if you have any questions about psychotherapy or our office policies. Your signature indicates that you have read our Outpatient Services Contract and agree to enter therapy under these





Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

conditions. Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

**I have read and agreed to the terms in the outpatient services contract (pages 1-3).**

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

**Notice of Privacy Practices**

**I have read the notice of privacy section (pages 3-6).**

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (if minor): \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (if minor): \_\_\_\_\_ Date: \_\_\_\_\_



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

## Rates and Cancellation Policy Agreement

Therapy is a commitment of time, energy, and financial resources. Motivated Wellness Solutions, LLC is committed to providing all clients with exceptional mental health care. When a client cancels without giving enough notice, they prevent another client who may have benefited from that appointment.

**New clients:** Any new client who fails to show for their initial appointment without communication with staff will not be rescheduled.

**Established Clients (for billing purposes only):** For those who have met with a clinician for at least one appointment is considered an established client.

At this time only teletherapy is offered. Limited insurances accepted and self-pay. Fees are reviewed annually.

Our current out of pocket fees are as follows:

- Initial Intake Appointment: \$250
- Individual Counseling Sessions (50 Minutes): \$200
- Couples/Family Counseling Sessions (50 Minutes): \$200
- Group Counseling Session: \$75

**Cancellation Policy: If you need to cancel your appointment, please give a 24hr notice. If 24hr notice is not given, you will be charged a \$100 fee. No call/no show will be charged full session fee.**

**Group sessions which are subject to a \$30 late cancel charge, and No call/no show will be charged full session fee.**

**Insurance companies do not pay charges for missed appointments, you are responsible for the fee out of pocket for late cancellation, or no call/no show fees.**

If fees for services are not paid in 60 days, a 25% charge will be added to an account to accommodate for this. If fees are not paid in a reasonable amount of time, and attempts have been made to resolve the financial matter to no avail, a client account may be sent to a collection service. Acceptable forms of payment via HIPAA compliant digital platforms and are due at time of service.

Additional services (such as letter writing, forms, consultations with other providers): \$150/hr prorated.

By signing below, I have read, understood, and agreed to the Statement of Rates and Cancellation Policy Agreement:

\_\_\_\_\_  
Client Name (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Guardians Signature if client under the age of 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Name (Signature)

\_\_\_\_\_  
Date



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

## Email Communication Informed Consent

Information contained in email messages may be privileged and confidential. There is some risk that any protected health information that may be contained in such email may be disclosed to or intercepted by unauthorized third parties. Please be aware that email communication can be intercepted in transmission or misdirected. Your use of email to communicate protected health information to us indicates that you acknowledge and accept the possible risks associated with such communication.

Motivated Wellness Solutions, LLC will respond to your email query, but to do so via email, you must provide your consent, recognizing that email is not a secure form of communication. I will use the minimum necessary amount of protected health information (PHI), to respond to your query. Please consider communicating any sensitive information by telephone, fax, or mail.

If you wish to conduct discussions regarding your mental health treatment via email, please indicate your acceptance of this risk by signing below.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing below, I (we) have read, understood, and agreed to the Statement of Informed Consent for Email Communication:

\_\_\_\_\_  
Client Name (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Name (Signature)

\_\_\_\_\_  
Date

## Informed Consent for Teletherapy



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

I \_\_\_\_\_ (Client name) agree and give consent for psychotherapy and treatment

by \_\_\_\_\_ (Therapist) using an Internet based platform/software. I understand that the platform/software is considered secure and encrypted and meets HIPAA standards of use. I understand that there are certain risks involved in entering this therapeutic relationship and that those risks have been explained to me.

I understand that online counseling services include, but are not limited to, consultation and treatment using interactive audio, video, and/or data communications. I understand that online counseling services involve the communication of my medical/mental health information to the above referenced provider. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any benefits to which I would otherwise be entitled. I understand that the laws that protect the confidentiality of my medical information also apply to online counseling services. I understand that the dissemination of any information is under the same HIPAA standards as traditional therapy.

Although rare, I understand that there are risks to Internet based services including, not limited to, the possibility, despite reasonable efforts on the part of the online platform being used and/or Therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

By participating in online therapy services, I am aware of potential benefits and risks. Some benefits may include improved access to services, being able to choose the therapist I want with specialty experience, the convenience of not having to travel to a therapist and using whatever means of communication I am comfortable with. Although risks are rare, I am aware there are possible risks which include that the information I can give may not be sufficient to allow for a diagnosis, that there may be delay in response from my therapist due to technical failures or unforeseen events, and that I may not be able to respond to my therapist due to my own technology failures or unforeseen events. I understand that my therapist may not be able to provide certain services to me.

Informed consent continues throughout the course of therapy and my therapist will continue to talk with me about risks, benefits or educate me on the process of therapy as we go along. I agree to pay the stated cost for services and understand that there are no refunds for services rendered.



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

By signing below, I (we) have read, understood, and agreed to the Statement of Informed Consent for Online Counseling/Teletherapy:

\_\_\_\_\_  
Client Name (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Guardians Signature if client under the age of 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Name (Signature)

\_\_\_\_\_  
Date



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

## Informed Consent for Psychotherapy

### General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

### The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

### Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons.

Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a way there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.



Motivated Wellness Solutions, LLC  
Clinical Counseling, Consulting, and Coaching  
Phone: 740.233.6357  
Email: [asmitke@motivatedwellnesssolutionsllc.com](mailto:asmitke@motivatedwellnesssolutionsllc.com)

By signing below, we have read, understood, and agreed to the Statement of Informed Consent for Psychotherapy.

\_\_\_\_\_  
Client Name (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Name (Printed)

\_\_\_\_\_  
Guardians Signature if client under the age of 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinician Name (Signature)

\_\_\_\_\_  
Date