LAKE COUNTRY ASSOCIATES, INC.
515 Bridge Street East, Park Rapids, MN 56470 ph: 218-366-9229
1426 Bemidji Ave NW, Ste 1 Bemidji, MN 56601 ph: 218-444-2233
11 Main Street East Menahga, MN 56164 ph: 218-564-9229
Fax: 218-237-2520

Informed Consent for Assessment and Treatment

NAME: _____ Date of Birth: _____

1. I understand that as a participant in mental health services at Lake Country Associates (LCA) I am eligible to receive a range of mental health services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

2. I understand that all information shared with the clinicians at LCA is confidential and no information will be released without my consent. During the course of treatment at LCA, it may be necessary for my clinician, ARMHS Mental Health Practitioner or mental health provider to communicate with other LCA staff and clinical business associates of LCA. My authorization for the release of information within LCA acknowledges my awareness of this communication. The purpose of this communication is to provide for continuity of care, consult on diagnosis, treatment planning or recommendations and is always done with the goal of providing the best and most appropriate services for my needs. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

    a. When there is risk of imminent danger to me or to another person; the clinician is ethically bound to take necessary steps to prevent such danger.
    b. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder and to inform the proper authorities.
    c. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

3. I understand that a range of mental health professionals and practitioners, some of whom may be in training, provide LCA services. All professionals-in -training are supervised by licensed staff. I will be informed if the professional I am seeing is receiving supervision and is in training.

4. I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

5. The Counselor-Client relationship is unique in that it is exclusively therapeutic. In other words, it is almost always inappropriate for a client and a counselor to spend time together socially, to give each other gifts, or to attend functions together. The purpose of these boundaries is to ensure that you and your counselor are clear in understanding your roles for treatment and that your confidentiality is maintained.

Chart # _____

Continued on the
Next Page . . .

6. If there is ever a time when I believe that I have been treated unfairly or disrespectfully, I can discuss the situation with my mental health provider. Any issues that might interfere with the counseling process should be identified and discussed as quickly as possible. This includes personal, family, administrative, financial and other issues.

7. Office Policies: Most counseling sessions last 45 - 50 minutes, but occasionally 20 - 30-minute sessions may be scheduled. We attempt to end each session promptly. Payment of co-pays or uncovered services is requested at the time of your appointment. We can accept cash or checks for your payment. If you must cancel an appointment, we ask that you call our office at least 24 hours in advance. A late cancel or no showed appointment may result in a no-show fee. Repeated No Shows or Late Cancels may also result in limited availability for you to reschedule future appointments.

8. Our telephone is answered 24 hours a day by a digital answering system. Throughout the day we check messages and whenever possible we try to return phone calls the same day. If we have not returned your call within 24 hours, please try again. If you leave a message after office hours the message will be checked the following morning. On Fridays after closing at 1:00pm, calls go to the answering machine and will be checked on Monday mornings. If you have an emergency after hours or on the weekend, please call 911 or go to your closest emergency room.

9. LCA has my permission to contact me using:

Text YES _____ (initial) _____ (cell phone number) NO _____ (initial)

Email YES _____ (initial) _____ (email address) NO _____ (initial)

If I have any questions regarding this consent form or about the services offered at Lake Country Associates, I may discuss them with my mental health provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Lake Country Associates. It is understood that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

_____ _____

Client or Legal Guardian Signature **Date**

IF CLIENT IS A MINOR

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

_____ _____

Signature of client's guardian **Date**

Name of minor child: _____

Minor child's date of birth: _____

Relationship to minor child: _____

Chart # _____