

File# _____

Name _____

Robert P. Gerholz Center for Christian Counseling Statement of Understanding

Thank you for allowing us to assist you and choosing our services to address issues that you have determined to be problematic. As your counselor, I believe that sharing key information will assist you in the counseling process. Please read the following information carefully.

SCHEDULING, CANCELLING OR MISSING APPOINTMENTS: Commonly, counselees come once per week for a standard counseling hour (45 minutes). The date and time of appointments are scheduled with your counselor, normally at the end of each session. Because this time is scheduled exclusively for you, cancellations and “no shows” can impact the wise use of time, please note the date and time of your next interview and be conscientious to keep your appointments.

PROVISION OF CHILDCARE: We are unable to provide childcare for counselees at the Center. If you, as an adult, are here for counseling we encourage you to arrange for childcare outside of the Center. If your child is being seen for counseling and is in the Waiting Room, you are responsible for oversight. If children are able to watch themselves, they may wait for their parents in the Waiting Room. However, in instances where problems may arise, your counselor will be contacted and you will be asked to manage the situation.

LENGTH OF THERAPY AND RISKS INVOLVED IN THERAPY: The establishment of a counseling relationship often takes time. Trust needs to be built before counselees are willing to share sensitive personal information. Because we understand this dynamic, a counselee’s need for and use of counseling time may vary.

For most individuals, the counseling process underscores a need to implement changes in thinking and behavior. This process involves a desire to produce change and the work necessary to put that change in motion. Change can be challenging. Your counselor is trained to serve in a variety of roles to facilitate, validate, direct and encourage positive life changes.

If the counseling process involves looking into one’s past or any type of trauma, some individuals experience a temporary increase in vivid dreams, intense emotions, impaired concentration and physical aches. These body responses are often an indicator that a person is working with root emotional issues. These responses should subside as the counseling process moves forward.

USE OF MEDICATIONS: The use of certain medications and supplements may have an impact on your psychological well-being. The use or disuse of any medication/supplement should be reported to your counselor. Although the counselor may make routine inquiries about medication usage, it is important that you, the counselee, communicate any changes in medication usage.

EXTENT OF CONFIDENTIALITY: Everything said by you, and to you, in the counseling relationship (as well as any testing or evaluation) is kept in the strictest confidence. **Nothing** will be communicated to **anyone** outside of our staff, either verbally or in writing, unless you, or your legal guardian if you are under eighteen years of age, sign an official release of information form. This form will specify: a) what type of information will be released, b) to whom; c) for what purpose; and d) the length of time the release will be effective. In an effort to maintain the highest standard of excellence, Case Reviews and Clinical Supervision are performed by designated staff personnel. This does not constitute a violation of confidentiality. Strict security measures are used to maintain the protection of all interview notes.

LIMITATIONS OF CONFIDENTIALITY: Confidentiality may be broken by your counselor in the following specific situations:

- a. **If** there is a reason to believe that you may be a physical threat to your own safety or well being (as outlined by Professional standards).
- b. **If** there is reason to believe that you could be physically harmful to another person. In such cases, all appropriate people will be notified, including the police and the person(s) at risk.
- c. **If** information shared with a counselor gives them *reason to suspect* that:
 - 1. a child has been harmed or is in danger of being harmed mentally, physically or sexually, in accordance with State Law pertaining to Child Abuse and Neglect, **then** this information will be shared with Child Protective Services or the appropriate local Law Enforcement Agency **or**
 - 2. an elderly or disabled person has been financially exploited or harmed mentally, physically or sexually or is in danger of being financially exploited or harmed in any of these ways, in accordance with State Law, **then** this information will be shared with Adult Protective Services or the appropriate local Law Enforcement Agency.
- d. **If** the counselor receives a subpoena or court order signed by a judge, then he or she shall release requested information to the court.

SIGNATURES ATTACHED TO THIS AGREEMENT: I have [] carefully read, or have [] had read and explained to me in a language I can understand, this entire Statement of Understanding. By attaching my signature below, I am agreeing to all items discussed herein, as well as giving authorization to receive services for [] myself [] for (dependents under eighteen) _____.

Client/Guardian/Parent Signature

Date

Witness (Counselor) _____
