

**Clymene Baugher, M.A., LMHC**  
Licensed Mental Health Counselor

**Psychotherapy For Artists & Creative Professionals**  
352-250-7797  
www.clymeneco.com

**INFORMED CONSENT FOR ASSESSMENT AND TREATMENT**

Thank you for choosing Clymene Baugher, M.A., LMHC private practice. Today’s appointment will take 45-50 minutes. Our first meeting will involve discussing informed consent, as well as billing and payment. I also will perform an initial assessment, after which I will provide some clinical impressions of what the course of treatment might be like and what you can expect from the therapeutic process. I realize that beginning counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, state and federal laws, and your rights. If you have any questions or concerns, please do not hesitate to ask; I will try my best to give you all the information you need.

My practice is located at:

17 W. 74<sup>th</sup> St.  
No. 4A  
NY, NY 10023

**CONFIDENTIALITY**

I understand that all information shared with my clinician is confidential and no information will be released without my consent. **Consent to release information will be communicated with me and is given through written authorization.** I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- A. **Harm to self or others.** When there is risk of imminent danger (threats of suicide/homicide) to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger; for example, notifying potential victim, contacting police, or seeking hospitalization for client.
- B. **Abuse or neglect.** When there is suspicion that a child, elder, or disabled person is being sexually or physically abused or neglected, or is in risk of such abuse, the clinician is legally required to take steps to protect and inform proper authorities.
- C. **Legal proceedings.** When a valid court order is issued for medical records, the clinician is bound by law to comply with such requests.
- D. **Consultation.** When clinician finds it helpful to discuss client cases with another professional for the purpose of ensuring best possible treatment, though no identifying information is used and all mental health clinicians are ethically bound to uphold client confidentiality.

When applicable, a separate Informed Consent Agreement for Minors will be addressed and signed.

I understand that I may ask questions about informed consent at any time and that I am entitled to a copy of my signed Informed Consent Agreement upon my request.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PSYCHOTHERAPY & COUNSELING SERVICES**

Psychotherapy is an exceptional process, and can be intense and extremely meaningful. Counseling is meant to help clients gain support during difficult times, identify problems, and improve symptoms and maladaptive behaviors within the safety and warmth of the therapeutic relationship/environment, hopefully maximizing healthy decision-making and achievement of client goals. Therapy also aims to help clients achieve self-awareness and insight into their behaviors, thoughts, and feelings and ultimately come to understand patterns and how they relate to others. It is the hope of therapy that clients will develop an understanding of their past experiences and how those experiences have impacted functioning and relationships, in order to move forward in a positive manner, thus improving their overall sense of self, relationships, and satisfaction in life.

There are no guarantees about what you will experience. The first few sessions will involve an evaluation of client needs and goals. You should evaluate this information and decide whether or not you would like to continue working together. Psychotherapy involves a significant commitment and you should feel comfortable with the therapeutic relationship. If you feel that this therapist is not a good fit for you and/or your current needs and goals, this therapist will help you secure an appropriate consultation with another mental health professional. It is encouraged that you address these concerns openly in session as the exploration of such are often beneficial to treatment.

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.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Date

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

**PROFESSIONAL RECORDS**

Both laws and standards of the mental health profession require that counselors keep appropriate treatment records. These records are kept in a secure and locked location. You are entitled to receive a copy of your records at your written request, unless counselor professionally believes that seeing them would be emotionally harmful to you. If you request your records, it is recommended that you and therapist review them together to discuss their content. If you are denied access to your records because therapist believes seeing them would be harmful to you, you may appeal that decision to the New York State Department of Health.

**SESSIONS & FEES**

Session frequency may vary depending on your needs.

My fee for initial assessments is 200.00 and 150.00 per fifty-minute session thereafter; together we will decide on a fee that feels manageable for you: I will inform you in advance of any changes in fees. Fees are discussed and agreed upon during the initial consultation/assessment. I do offer a sliding scale fee for students, dancers, freelance artists/creative professionals, and people experiencing economic difficulties.

You will be expected to pay for each session at the time it is held, unless an amended schedule has been made between therapist and client. You may **pay in cash or by check made out to Clymene Baugher**. In circumstances of financial hardship, a fee adjustment or payment plan may be arranged.

If you do not pay for services and we have been unable to agree on a payment plan, this therapist has the option of using legal means to secure payment, including collection agencies or small claims court. In such cases, therapist would release limited information about you including name, type of professional services rendered, and amount due. You also will be responsible for collection fees required for collecting the debt.

There is a 25.00 fee for bounced or returned checks.

Please provide 24-hour notice for all cancelled appointments. There is no penalty for canceling and rescheduling an appointment; however, you will be responsible for paying the full session fee for missed appointments without notice. Additionally, "no show/ no call" appointments may be grounds for termination of treatment.

A separate Fee Schedule Form will be discussed and signed with therapist during initial assessment to confirm my personal fee for therapy and payment.

\_\_\_\_\_  
Print Name \_\_\_\_\_ Date

\_\_\_\_\_  
Signature \_\_\_\_\_ Date

**CONTACT**

**You may reach Clymene Baugher, M.A., LMHC at 352-250-7797**

I will make myself as available as I can for ongoing telephone communications. It is sometimes not possible for me to be available immediately by phone; however, I routinely check my voicemail for messages during regular business hours and usually calls are returned within 24 hours. When you leave a message, please let me know some times when you will be available and the best number(s) to reach you during those times.

If I will be unavailable for an extended period of time, I will indicate the length of my absence and inform you in advance. **If you experience an emergency, call 911 or go to the nearest hospital emergency room and request to be seen by a mental health professional.**

Email communication is not guaranteed to be confidential. It is recommended that you use email to discuss general concerns, nothing specific or private. Email can be a good way to cancel or change an appointment time. It should not be used for emergencies.

Your signature below indicates that you have fully read and understood the information contained in this document and that you agree to its terms. Your signature indicates that you consent to evaluation and treatment offered by Clymene Baugher, M.A. LMHC.

I understand that I may stop treatment at any time.

\_\_\_\_\_  
**Print Name** \_\_\_\_\_ **Date**

\_\_\_\_\_  
**Signature** \_\_\_\_\_ **Date**