Behjat Shirazi, MA LPCC
6666 4th Street NW
Albuquerque, NM 87107
505-263-0821

INFORMED CONSENT FOR TREATMENT

I, _____(Client) and/ or _____
Legal Guardian, voluntarily consent to receive Clinical Psychotherapy services provided by Behjat Shirazi, MA, LPCC. My right to refuse consent to services is fully explained to me.

CONFIDENTIALITY:

I understand that all and any information discussed during my counseling sessions is confidential. That no information may be revealed to another person/agency without my explicit written permission, except as required by law. The exceptions to confidentiality are as follows:

Your Therapist is committed to protect the confidentiality of all information shared in the course of Counseling sessions (according to Ethical Standards, FERPA, HIPPA and state law requirements), except for compelling professional reasons. The general expectations your Therapist must release information without your written permission are: 1) when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. 2) Response to a valid court order or subpoena or, 3) you are reporting abuse of children, the elderly, or persons with disabilities. Only information that is directly relevant to the purpose for which the disclosure is made will be revealed. This is in accordance with the Federal Freedom of Information At, The New Mexico Mental Health Code, and the New Mexico Failure to Warn Status

STATEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES

As a client of Ms. Behjat Shirazi, MA, LPCC, you have the right:

- To be treated humanely, with dignity and respect at all times. To a safe and accepting therapeutic environment which is void of judgmental attitudes and labeling.
- To be fully informed of your rights and responsibilities relative to your Therapy.
- To receive timely response from Ms. Shirazi regarding your treatment.
- To reasonable privilege of privacy and freedom of thought, conscience and religious and spiritual beliefs.
- To have your thoughts, decisions and ideas heard and be included in your treatment goals and objective.
- To review your clinical records at your request with your Counselor whenever you request them.

- To be fully informed in advance of any anticipated break, transfer or termination of services by Ms. Shirazi.
- Be ensured that your therapy records are kept in a confidential manner as required by HIPPA and New Mexico State Ethical Standards & Laws. Reasonable access to your records will be provided at your request. To complete information about your treatment in an easily comprehensive manner. This will include discussions about the risks and benefits as well as the cost of treatment.
- To be informed about your Therapist's qualifications and credentials. For additional information about Ms. Shirazi's credentials, qualifications, background, philosophy of Counseling, and other frequently asked questions, please visit her website at: www.shirazicounseling.net.
- Be provided the opportunity and/or information about filing a grievance if and when requested.

CLIENT RESPONSIBILITIES:

- Give accurate and complete information concerning your need for treatment, prior treatments, medications, medical and emotional history, and any other information that would be helpful for yourself and your Therapist to determine the best form of treatment necessary in order to reach your goals for seeking Counseling.
- Assist your Counselor in developing and maintaining a safe therapeutic environment.
- Provide your Counselor with a minimum of 24 hour notice when you need to cancel appointments.
- Participate fully in your treatment plan and follow up. Take full responsibility for your own well being and ask for understanding and help whenever you need to.

OFFICE HOURS AND AVAILABILITY:
The office hours are flexible. Appointments can be set up any time between the hours of 7:30 AM to 7:30 PM M-F, based on client/counselor agreement and availability. Saturday appointments are made as needed. Ms. Shirazi can be reached by phone at 505-263-0821, voice messaging is available and she will return calls promptly within two hours. She can also be reached via email at: Behjat@shirazicounseling.net. In cases of medical emergency, please call 911 or your medical provider.

Clients will be informed of any vacation time taken by Ms. Shirazi two weeks in advance. Backup coverage by other highly qualified Counselors are available upon request and need of the individual clients as is agreed upon with the Counselor.

SCHEDULING OF APPOINTMENTS AND FEES:

Counseling sessions will be arranged between the client and Counselor based on the therapeutic needs and availability by both parties. Clients are responsible for payment of fees, co-payments in form of cash or personal check at time of service. Agreements can be reached regarding insurance billing and/ or payment plan. The fee for a 50 minute hour session service is $85, with consideration given for a sliding scale due to financial concerns. The agreed upon fee for services are: _____ per session. Except in cases of emergency, please allow 24 hours in advance for cancellation. Failure to do so will result in a full payment for the missed session. Insurance will not be billed for missed sessions.

INSURANCE:

My office will bill your insurance carrier. It is your responsibility to determine coverage and co-pay amount. Some companies will require prior authorization obtained by the client. Your signature below authorizes my office to release information required by your insurance carrier for reimbursement for services rendered.

OTHER SERVICES:

Services other than in-office 50 min. sessions such as phone consultations, court appearances, report writing and consultation with other professionals will be billed at the regular hourly rate.

I fully understand and agree to the above information about my Rights and Responsibilities, informed consent, and issues around confidentiality and service delivery. I also understand and agree that I have the right to terminate Counseling services by Ms. Behjat Shirazi MA, LPCC at any time.
Please sign below to acknowledge having read, understood and agreed to the above.

Client Signature:_____ Date: _____
Legal Guardian_____ Date:_____

Behjat Shirazi, MA, LPCC:_____ Date _____