



Robert Lusk, Ph.D. & Michelle Staley, MA, LCPC, CADC, LFYT-II  
1100 N. Beech St., Building #7 Office #7, Normal, IL 61761  
[www.mettacounseling.com](http://www.mettacounseling.com) Phone: 309.287.9722

## INFORMED CONSENT

Thank you for choosing Metta Counseling. Today's appointment will take approximately 50-55 minutes. This document is intended to inform you of our policies, state and federal laws, and your rights. If you have any questions regarding the information presented, please feel free to ask.

Robert Lusk is licensed by the state of Illinois as a Licensed Clinical Psychologist. He obtained his Doctorate in Clinical Psychology from U.C.L.A. and has been practicing since 1988. Michelle Staley is licensed by the state of Illinois as a Licensed Certified Professional Counselor. She obtained her Master of Arts degree in Clinical Psychology from Illinois State University. She has been practicing since 1995 in various community settings. Our approach to therapy is typically client-centered and cognitive-behavioral.

Therapy can be a safe place to discuss your feelings, identify life goals, and work on personal growth. There can be a risk to therapy as well; therapy can bring about painful feelings or memories which may lead to an increase in the symptoms that brought you to therapy initially. This is usually temporary and can often be resolved by continuing to work with those feelings or memories.

### Confidentiality:

The information shared with us in the counseling setting is confidential with the following exceptions:

- Mandated reporting of child abuse or neglect.
- Mandated reporting of elder abuse or neglect.
- Threats of suicide or homicide.
- Written consent to release personal information.
- Court orders according to legal requirements and APA ethical guidelines.

In the event of the death of the therapist, your records can be obtained through the therapist's estate.

### Emergency situations:

If an emergency arises outside of our business hours, you have several options;

Dial 911 for immediate attention.

Call PATH, a 24/7 crisis and referral hotline, at (309) 827-4005.

Go to your nearest emergency room.

### Financial options:

This practice charges \$80.00 - \$120.00 per 50-55 minute session. Payment is due at the time of service. Any unpaid balance over 90 days, without prior authorization, will be turned over to a collection agency.

Please give this office 24 hours notice if you are unable to attend a scheduled appointment. The regular session fee will be charged for no-shows or cancellations without 24 hours notice.

Coordination of treatment:

Were you referred by a physician? If so, we can inform her/him of your treatment here.

Y N Permission is granted to inform the referring physician that I am being treated.

Client Contact:

I would like to be contacted by:  Home telephone  Work telephone  Cellular telephone

Y N Metta may leave a message on the answering machine or voice mail.

Y N Metta may leave a message with another person (spouse, child, receptionist).

Notice of Privacy Practice and Clients' Rights:

I have received and read a copy of the notice of Privacy Practice and Clients' Rights documents.

Informed Consent for Treatment of Minors:

I consent that \_\_\_\_\_ may be treated as a client by Metta Counseling.

My signature below indicates that I have read and understood the above information including confidentiality, emergency situations, financial agreements, coordination of treatment, client contact, and that I have received and read a copy of the notice of Privacy Practices and Client's Rights documents.

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Metta Counseling will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions. I hereby consent to treatment by the specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X \_\_\_\_\_  Client  Parent  
Signature Date

X \_\_\_\_\_  Client  Parent  
Signature Date

X \_\_\_\_\_  Client  Parent  
Signature Date

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