Welcome to Clearwater Counseling Group

As you begin your counseling journey at Clearwater, it is import to take note of our policies and procedures. Please read this welcome sheet thoroughly and feel free to clarify any questions with your therapist.

Office Hours and Availability

Specific appointment times are dependent upon the availability of your therapist, who will schedule with you directly.

Please be aware that we do not provide emergency services. Therefore, our therapists may not be able to respond to an emergency message in a timely manner. If you are experiencing a crisis, please call 911 if appropriate. Other numbers that may be helpful should the need arise:

OSU / Harding Medical Center	(614) 293-9600
Riverside Hospital	(614) 566-5056
Suicide Prevention	(614) 221-5445

Confidentiality

What you disclose in therapy is held in very strict confidence. If there is a need for your therapist to discuss identifying information about you and your treatment to anyone else, you will be given a written Release of Confidential Information form to complete and sign. If your therapist is under supervision, you will be asked to sign a consent form to release information to the supervisor. There are exceptions when information will not be held confidential, but shared with the appropriate person or agency without prior client consent. The exceptions apply to the client or anyone in the session with the identified client.
Exceptions mandated by sate laws and are as follows:

1. The person threatens suicide
2. The person threatens to harm someone (including murder, assault, or physical harm)
3. The person is a minor and reports potential child abuse (including, but no limited to physical beating, physical neglect, and sexual abuse)
4. The person reports abuse of the elderly or mentally disabled
5. The person reports sexual exploitation by a therapist

Please note that insurance companies require varying levels of confidential client information in order to "authorize" sessions or process claims. Please be aware of this if you submit claims for reimbursement from your insurance company.

Additionally, please do not invite your therapist to join any of your social networks online.

Services and Fees

Customary session length is between 45-50 minutes per clinical hour. This provides for appropriate clinical intervention and allows time between sessions for your therapist to review clinical notes, complete paperwork, consult with other professionals, and manage scheduling. We will attempt to start and finish sessions in a timely manner. Occasionally, your therapist may have to address a critical clinical need and may run late or need to cancel without timely notice. We appreciate your understanding on these rare occasions.

Our fee schedule is as follows:

Diagnostic Interview Evaluation (1st session; 60 minutes)	$160.00
Individual (60 min.), Marital, or Family session	$145.00
Psychological Testing or Assessment Tools	Prices vary per service

Psychological testing and other assessment tools may provide useful information in a time and cost-efficient manner. If your therapist determines further assessment tools would be helpful, specific rates will be discussed prior to administration.

Clearwater counseling will not be submitting claims to insurance on your behalf. Please remember you are responsible for payment the time of service.

Cancellation Policy

Occasionally, you may need to change a scheduled appointment time. We understand that illness or scheduling conflicts happen. However, due to the nature of the practice, we reserve our clinical time exclusively for you and urge you to do your best to maintain consistent attendance. Please make every effort to give as much time prior notice if you need to change an appointment time. Clients are charged the full clinical rate for “no shows” or same-day (less that 24 hours) cancellations.

Child / Adolescent Counseling

On occasion, the therapist may ask a caretaker to come alone to the initial Diagnostic Interview if a child or teenager is the client. Subsequent sessions may involve just the child, of the child and family, depending on the particular situation and the therapist’s clinical judgment. Parents are encouraged to provide the therapist with any relevant information for their child’s care (report cards, prior assessments, physician information, other records, etc.)

Please understand that any children or adolescents who attend counseling at Clearwater as clients or as the dependents of adults receiving services are ultimately the responsibility of the parent/guardian. Children under ten years of age are not to be left in the waiting room without guardian supervision.

In cases of divorce of blended families, we look to the parent whose signature is on the consent form for treatment to be fully responsible for payment. If the court system has designated one party to cover out of pocket medical expenses, or for each party to share out of pocket medical expenses, that will be for the parties to work out on their own. As a policy, we will not become involved between divorced parties regarding payment.

Clients with Disabilities

We will do our best to accommodate clients who have physical disabilities. We request that clients with Physical limitations of special needs to discuss these needs with their therapists at intake so that appropriate arrangements maybe determined. We are not able to provide services to adult clients who are not mentally competent to consent to treatment, but we will assist with an appropriate referral.

Commitment from Clearwater Staff

We at Clearwater Counseling Group consider it a privilege to serve your counseling needs. We will strive to provide each client and family with high quality care. We are committed to treating you with respect and dignity as you work towards greater health and healing. Please request a copy of this for your records or as a reference if you would like one.

I have read this and I accept the terms and policies outlined including the limits of confidentiality, and I consent to receive mental health services at Clearwater Counseling Group.

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Client Name (Please print) Date

____ ____
Client Signature (or guardian) Date Therapist Signature Date