Diane K. Schmidt Counseling Services
Diane K. Schmidt, LSCSW

INFORMED CONSENT & THERAPY CONTRACT

It is important that you are fully informed about the services you will receive. By signing below you are saying:

1. I understand that my therapist is licensed by the State of Kansas as a Licensed Specialist Clinical Social Worker, LSCSW #4169, and is a member of the National Association of Social Workers.

2. I understand that the therapist is bound by the Code of Ethics set forth by the National Association of Social Workers, and I can request a copy of these ethics at any time.

3. I understand the confidentiality policies detailed in the **"Client Information Form",** including the circumstances in which Kansas Law may permit or mandate limits to confidentiality.

4. I understand that there are risks and benefits associated with therapy and I have discussed those with my therapist to my satisfaction. I also understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

5. I understand that I may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session, rather than by phone, email or text message.

6. I understand that, under Kansas Law, my therapist is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request.

7. I understand the appointment and financial policies and agree to pay the full visit fee for therapy at the end of each session, which is approximately fifty minutes in length.

8. I have received the client information form that informs me of my rights and other pertinent information, and the information has been explained to me and any questions answered by my therapist.

My signature below indicates that I give my full and informed consent to receive therapy services with Diane K. Schmidt Counseling Services.

Signature _____ Date _____

Signature _____ Date _____