

**RUTH E. FIELD, MSW, LCSW**  
MASTER OF SOCIAL WORK, LICENSED CLINICAL SOCIAL WORKER

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466 Central Avenue • Suite 2 • Northfield, Illinois 60093  
**Phone:** (847) 977-4741

**CLIENT ACKNOWLEDGMENT &  
INFORMED CONSENT**

**CLIENT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**I. INTRODUCTION: A GENERAL DESCRIPTION OF PSYCHOTHERAPY SERVICES**

Psychotherapy is not easily described in general statements. It varies depending upon the personalities of the mental health professional and the client, as well as the particular problems you are experiencing. There are many different ways to deal with the problems you hope to address. Psychotherapy is a collaborative effort between therapist and client.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are, however, no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. During this time we can both decide if we are compatible to work together toward your therapy goals. By the end of this period, I will be able to offer you some general impressions of what our work will include, and an initial treatment plan to follow. You should evaluate this information carefully, along with your own sense of whether you feel comfortable working with me.

Therapy often involves a significant commitment of time, money, and energy, so you should be thoughtful about the process. If you have any questions about my recommendations or procedures, we should discuss them whenever they arise. If, for whatever reason, either of us does not feel that we are well suited to proceed, I will assist you with a referral to another mental health professional.

Therapy sessions are generally 50 minutes in length and scheduled on a weekly basis. However, the frequency and duration of sessions may vary depending on specific clinical needs.

**II. METHODOLOGIES UTILIZED**

During the course of therapy, the **Provider, Ruth E. Field, LCSW**, is likely to draw on various methodologies depending on the problem and what is in the Provider's professional judgment, in the best interest of the Client. If the Client has any questions about any of the procedures used in the course of therapy, including risks, the Provider's expertise in employing them, or about the treatment plan, the Client should not hesitate to ask. The Client also has the right to ask about other treatment methodologies. If the Provider concludes that the Client could benefit from any treatments outside of the Provider's area of expertise, there is an ethical obligation to assist the Client in obtaining those treatments, should the Provider conclude that the suggested approach would be in the Client's best interests.

### III. EMERGENCY SERVICES

By signing below, the Client understands that the services provided by **Ruth E. Field, LCSW** are offered in the form of **regularly scheduled visits of a non-emergency nature**. The Client understands that this office is **not** set up to provide emergency services and has engaged in treatment with the Provider with the understanding that, should emergency services be required, the Client should call 911, or will need to seek services at the nearest emergency room, or contact another therapist/practitioner that provides emergency services, including through referrals made by the Provider, if any, or seek out crisis services within their own community. If necessary, I will assist you with the development of a detailed crisis plan as part of our work together.

Regarding voicemail messages, the Client understands that messages are retrieved once a day Monday through Friday, and that messages left over the weekend are retrieved on Monday of the following week. Always be sure to leave contact numbers, times you will be available, and any special instructions with respect to leaving messages with family members or co-workers. Should it become clear to the Client, to the Provider, or both, that the nature of the presenting concerns exceed the availability of this office, referrals will be offered.

### IV. CONSULTATION WITH OTHER QUALIFIED PROFESSIONALS

Mental health providers consult regularly with other highly qualified professionals regarding their clients; however, clients' names or other identifying information are never mentioned and confidentiality is fully maintained.

### V. INITIAL ASSESSMENT; TERMINATION OF TREATMENT; REFERRAL TO OTHERS

After the first few meetings, the Provider will assess if he/she can be of benefit, as a competent clinician does not accept clients who, in her professional judgment, she cannot help. In such instances, the Provider will refer the Client to other professionals. In addition, if at any point during treatment the Provider assesses that she is not effective in helping the Client, termination of treatment and referral to others is an ethical obligation that cannot be circumvented. Finally, all clients have the right to terminate treatment at any time, for any reason. If this is the Client's choice, the Provider will offer to provide names of other qualified professionals.

### VI. MANDATED REPORTING

The Abused and Neglected Children's Reporting Act in Illinois requires that "mandated reporters" must disclose any suspected instances of abuse or neglect of minors to the Illinois Department of Children and Family Services. The Provider is a mandated reporter, as are all mental health service providers. The only requirement is that the "provider" has a good faith belief or conclusion that a neglect or abuse situation exists. If this is so in the mind of the Provider, the law **absolutely requires** that a phone call be made to DCFS, such that DCFS may investigate the situation. If such a report is made, it is the policy of this office to first advise the Client that the report will be made. Subsequent to a "mandated" report, the Client, and possibly others, will be contacted by a follow up investigator from DCFS. If these investigators confirm the presence of abuse or neglect, a letter so indicating will be issued, and possible court hearings could result. If the DCFS investigators conclude that no abuse or neglect has occurred, a letter will be issued indicating that the claim is "unfounded." **The Provider has no choice but to make reports in these situations.** The Client should be aware that the statute provides for loss of license if a mandated reporter fails to make a mandated report. The statute also provides the Provider with absolute immunity from any criminal or civil liability in the event that such a report is made, **even without the consent of the Client.**

### VII. DUTY TO WARN OF PHYSICAL INJURY

Under Illinois law, both the Illinois Mental Health and Developmental Disabilities Confidentiality Act and the Clinical Social Work and Social Work Practice Act, the Provider may

“warn” any intended victim, as well as the responsible authorities, and disclose confidential information, where a client discloses in session that he or she intends to cause **serious mental or physical harm to a specifically identifiable victim** and presents a clear and imminent risk of harm. It is then the Provider’s responsibility to take steps to notify the victim and/or local authorities and provide enough information with which the authorities and/or the victim might prevent the harm from occurring and/or in order to prevent a serious threat to public safety. Therefore, if a client discloses an intent to harm a specific person, the Provider must either contact that person and the authorities, or attempt to secure the hospitalization of the individual. These disclosures are also protected by an immunity clause in the statute.

#### **VIII. LEGAL PROCEEDINGS**

Per this Acknowledgment Form, the Client agrees that the Provider’s involvement will be strictly limited to the treatment of the Client in psychotherapy sessions during regular scheduled visits. The Client agrees that he or she will not attempt to gain advantage in any legal proceeding he or she may be involved in, such as a divorce or post-decree proceedings, from the Provider’s involvement in treatment of the Client, including adolescent clients whose parents are involved in such legal proceedings. Accordingly, the Client agrees that in any such legal proceedings, the Client will not ask the Provider to testify in a court of law, whether in person or by affidavit. Further, the Client agrees to instruct his or her attorney(s) not to subpoena the Provider or to refer in any court filing to anything the Provider has said or done. This provision shall be applied to the extent necessary under the applicable laws of the state. If for any reason the Provider is required by a court to appear as a witness, prepare records for release, give a deposition, and/or prepare an affidavit, the party responsible for the Provider’s participation agrees to reimburse her at the applicable rate per hour for time spent traveling, preparing, testifying, being in attendance, and any other related costs incurred, including the Provider’s attorney fees.

#### **IX. ADOLESCENTS & CONFIDENTIALITY**

Adolescents between the ages of 12 and 18 are entitled by law to limit access by their parents and others to their mental health records. It is my belief that adolescents and their families are best served by a reasonable expectation of confidentiality. This enables everyone to trust in the therapy process and use it optimally. Other than in situations of imminent danger, I will use my best professional judgment in order to help the parent and their child, the adolescent client, to communicate about these concerns.

#### **X. CANCELLATIONS**

I would greatly appreciate notification of the need to cancel a scheduled session as early as possible. This enables me to use my time to best benefit all of my clients. **Once an appointment is scheduled, you will be expected to pay for it unless you provide a minimum of 24 hours advance notice of cancellation.**

#### **XI. PROFESSIONAL FEES & INSURANCE**

My current fee is \$150.00 for a standard, 50-minute therapy session, and \$175.00 for an initial 75-minute intake. My fee may be prorated for sessions that are different in length. I may also charge this amount on a prorated basis for other professional services such as preparation of reports and records, attendance at school meetings, and telephone conversations lasting longer than 15 minutes.

Payments for services are expected at the time they are provided. I will provide you with a monthly statement indicating the dates of sessions, charges and payments, as well as all codes that are necessary for insurance reimbursement. As a Licensed Clinical Social Worker, I am usually covered as an out-of-network provider for many insurance companies, but it is your responsibility to check your particular benefits coverage. The monthly statement that you receive will enable you to file for reimbursement from your insurance company on your own.

**XII. REFERRAL FROM PROVIDER’S COACHING PRACTICE**

In the instance that the Client has been referred for psychotherapy services from Provider’s coaching practice, he or she understands that the Provider’s coaching practice is independent and separate from her psychotherapy practice as a Licensed Clinical Social Worker. Further, by signing below, Client agrees that the Provider offered other referrals to the Client for psychotherapy services, and it was the choice of the Client to engage in psychotherapy with this Provider. If at any time either the Client or Provider finds that therapist-client relationship is not working or if there is potential for a harmful effect to the Client, either party may terminate this relationship. Client agrees by signing below that the Provider will no longer serve as a coach to the Client, and that business relationship has been terminated. Provider will strictly provide psychotherapy services to the Client moving forward. Further, Client agrees that per this informed consent form, Client has been made aware of any present and the potential of future conflicts of interests related to this therapist-client relationship. The Client further understands that the psychotherapy services he or she agrees to engage in, are wholly different than the coaching services previously provided by this Provider.

**XIII. SOCIAL MEDIA POLICY**

The Provider’s primary concern is the privacy of the Client. In general, The Provider does not accept clients or former clients as *personal* friends or contacts on social media websites as it could compromise confidentiality. The Client is, however, welcome to participate on the Provider’s Facebook page, if he or she wishes. If there are any questions in this regard, the Client should bring them up when he or she meets with the Provider.

**XIV. ACKNOWLEDGMENT OF CLIENT**

I, the undersigned, wish to become a Client of **Ruth E. Field, LCSW** (the “Provider”).

The Provider has shared the above policies with me, and has explained their implementation and significance. I have been given a copy of this document, and fully understand it. I have also been advised that the Provider has offered no guarantees as to the success, or as to a specific outcome, of the treatment. Fully understanding the above information, it is my intention to proceed with and/or continue my treatment with **Ruth E. Field, LCSW** at this time.

**Client Name:** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness Name:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_ **Date :** \_\_\_\_\_