

# Informed Consent for Treatment

Venue Clinic | Ethan Taylor, LPC

## Welcome

This document is meant to outline your rights as a patient, as well as the limits and expectations of therapy at Venue Clinic. Please read it carefully and ask any questions before signing.

## 1. On the Treatment

Therapy at Venue Clinic follows no preset plan. The direction and course of the work are set by what you bring and what unfolds as we continue.

I practice a variable length session; your treatment begins at our first meeting and continues as an unbroken process until it ends. Each session concludes when the work of that meeting has reached its point, not according to the clock.

## 2. On Risk and Effect

Therapy can be challenging. You may become more aware of painful memories, uncomfortable feelings, or internal conflicts. This is not unusual and can be part of meaningful change.

Changes may include a reduction in suffering, a shift in how you relate to yourself and others, and the freedom to live differently. Specific changes, however, are not guaranteed and may take time.

## 3. On Confidentiality

Everything you say in treatment is kept confidential, with the following legal exceptions:

- If you are at imminent risk of harming yourself or someone else
- If there is suspected abuse or neglect of a child, elderly person, or vulnerable adult
- If your records are subpoenaed by a court of law

Outside of these situations, nothing we discuss can be shared without your written permission.

## 4. On Payment

Payment is made per session, either in cash or sent through the secure link on the "Payment" page of the clinic website: [www.venueclinic.com/payment](http://www.venueclinic.com/payment).

## 5. On Absence

Sessions canceled with less than 24 hours' notice, or simply missed, are charged at the full fee. Your appointment is reserved for you alone; its value is not determined by attendance.

## 6. On Contact

You may contact me by text and email for scheduling or other brief matters. **If you are experiencing a life-threatening emergency, call 911 or go to the nearest emergency room before contacting me.**

## 7. On Conclusion

You are free to end therapy at any time. If you wish, we can discuss this decision together. In some cases, I may recommend a referral if I believe another form of treatment would better serve your needs.

## 8. On Patient Rights

As a patient, you have the right to:

- Ask questions at any point about your treatment, fees, confidentiality, or this consent form
- End therapy at any time, for any reason
- Refuse any therapeutic technique or recommendation
- Request access to your records, within the limits of applicable law
- File a complaint if you believe your therapist has acted unethically or violated professional standards.

To file a complaint, you may contact the South Carolina Department of Labor, Licensing and Regulation (LLR):

South Carolina Board of Examiners for Counselors, Therapists, and Psycho-Educational Specialists  
110 Centerview Dr., Columbia, SC 29210  
Phone: (803) 896-4658  
Website: [llr.sc.gov/com](http://llr.sc.gov/com)

### **Description of Services and Estimated Costs**

Under the federal *No Surprises Act*, patients who are uninsured or self-pay have the right to receive a **Good Faith Estimate** (GFE) of the expected cost of their treatment. The intent of this law is to protect people from large, unexpected medical bills—most often in situations like hospital stays or surgical procedures that can run into the tens or hundreds of thousands of dollars.

Psychotherapy does not fit neatly into that model. The length, frequency, and total duration of treatment vary from person to person, and the course of the work cannot be predetermined. As a result, it is not possible to produce a single “blanket” estimate that meaningfully captures every patient’s treatment.

Nonetheless, I am fully committed to transparency. A Good Faith Estimate can be provided to you at any time upon request based on your current fee, meeting frequency, and the number of calendar weeks the clinic is open. This estimate will meet the requirements of the law while recognizing the open-ended nature of psychotherapy.

### Patient Contact Information

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Emergency Contact

An emergency contact is a person you designated to be contacted if circumstances arise that place you, or another, in immediate danger and require intervention outside the therapeutic frame.

- Name: \_\_\_\_\_
- Relationship to you: \_\_\_\_\_
- Phone Number: \_\_\_\_\_
- Is this person aware you are in psychotherapy?  Yes  No

If you choose not to provide an emergency contact, please initial here: \_\_\_\_\_. In the event of an emergency without a designated contact, I may need to involve emergency services directly to help ensure safety.

### Consent to Treatment

Typing your full name below constitutes your electronic signature and indicates that you have read, understood, and agreed to the terms outlined above; you agree to engage in therapy voluntarily and understand your rights and responsibilities as a Patient.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### **IMPORTANT NOTICE**

I understand that standard email is not a secure or HIPAA-compliant method of communication.

By initialing and submitting this form by email, I acknowledge the risk that my personal health information may be exposed in transit. I consent to using email for this one-time communication: the return of this completed form to my therapist.

I understand that this does not authorize the use of email for ongoing communication of protected health information (PHI).

If I prefer, I may print this form and bring it in person to my first appointment instead.

Initials: \_\_\_\_\_

Date: \_\_\_\_\_