



iHope Christian Care & Counseling, Inc.
1414 W. Evans St., Florence, SC 29501
(843) 702-0323
www.ihopeflorence.com

INFORMED CONSENT: Kevin Deas, MA, LPCA

In an effort to help you make informed decisions about your counseling experience, the following paragraphs are to tell you about your counselor's background and qualifications and about your rights and responsibilities as a client at The iHope Center. You will be asked to sign on the last page to indicate your consent to treatment after reviewing this information.

COUNSELOR:

Kevin Deas, MA, LPCA

QUALIFICATIONS:

I have completed my Clinical Mental Health Counseling, Master of Arts degree at Liberty University. My experience includes working with individuals, families, and groups. Additionally, I hold a Bachelor of Science degree in Psychology from Liberty University and am currently employed at Automatic Data Processing (ADP) as a Project Manager.

My clinical supervisor is Jessica Hayes, MS, LPC, LMFT, LPCS Candidate. She is currently licensed by the state of South Carolina as a Licensed Professional Counselor (LPC) and a Licensed Marriage and Family Therapist (LMFT). Under these licenses, she practices under the authority of South Carolina Department of Labor, Licensing and Regulation board. She and I will both follow all S.C. laws and regulations. If you have a complaint, you can contact my supervisor at (843) 702-0323. You also have the right to file a grievance with the following licensing agency:

South Carolina Department of Labor, Licensing and Regulation
110 Centerview Dr., PO Box 11329, Columbia, SC 29211-1329
(843) 896-4470

FEES STRUCTURE:

See attached Financial Policy and Fee Structure.

METHOD OF COUNSELING:

I am a Christian counselor, which means that my method of counseling is based on biblical principles and a Christian worldview. I affirm the iHope Statement of Faith and am a member of the American Association of Christian Counselors. While my beliefs impact and shape my work with clients, I am happy to work with clients who do not share my beliefs. During the counseling process, I will use various therapeutic techniques, including but not limited to: traditional talk therapy, worksheets, speaker-listener, prayer, role playing, homework, and Bible reading. While under supervision, I may also receive supervision via tape or live observation, always with your awareness and consent.

GOALS, RISKS, AND BENEFITS:

There is always a risk of emotional side effects from counseling. The counseling process may bring up painful emotions, and some symptoms may get worse before they get better. Our goal is to confront these issues and emotions together and to work through them with time. Other types of counseling, such as a support group, may be appropriate, and we can discuss this together.

LENGTH OF COUNSELING:

It is very difficult to predict the length of counseling, given the unique strengths and struggles for each person. I will provide counseling in a timely manner, with consideration for your cost and time. I will not prolong counseling without due cause. Each session will be 50 minutes in length.

CONFIDENTIALITY AND RIGHT TO PRIVACY:

Confidentiality is essential to the process of establishing an atmosphere of safety and trust, where information, thoughts, and feelings may be freely shared. S.C. Law Section 19-11-95 outlines our professional confidences and boundaries. While most communication between a client and counselor is confidential, the following limitations and exceptions do exist by S.C. Law Section 40-75-190:

- (1) as mandated by Section 63-7-310, requiring certain professionals to report suspected child abuse and neglect and Section 43-35-85, requiring certain professionals to report suspected abuse, neglect, or exploitation of a vulnerable adult;
- (2) to prevent a clear and immediate danger to a person or persons;
- (3) if the licensee is a defendant in a civil, criminal, or disciplinary action arising from the course of treatment, in which case confidences may be disclosed only in the course of that action;
- (4) if the client is a party in a criminal or civil proceeding, including a commitment proceeding;
- (5) if a client introduces his mental condition as an element of a claim or defense;
- (6) if there is a waiver of confidentiality previously obtained in writing, this information may be revealed only in accordance with the terms of the waiver. In circumstances where more than one person in a family receives treatment conjointly, each family member who is legally competent to execute a waiver must agree to the waiver referred to in this item. Without a waiver from each family member legally competent to execute a waiver, no confidences may be disclosed.

When necessary and appropriate, I will share my intent to notify relatives or the authorities before taking the above actions. This may not be possible in case of an emergency or a risk to safety.

In the case of marriage or family counseling, there is limited confidentiality, meaning the confidentiality belongs to the relationship and not the individual.

You may sign a written release of information to share treatment information with an outside party, such as a physician or pastor.

All communication that we have as client and counselor will become part of your clinical record. Records are the property of Kevin Deas, B.S. and are kept locked at The iHope Center. You have the right to see, request copies of, and request amendment to your records. In accordance with legal requirements, adult client records are disposed of ten years after treatment ends, and minor clients' records are disposed of either ten years after treatment ends or five years after the client's 18th birthday, whichever period is longer. At that time, all records will be destroyed.

COMMUNICATIONS AND APPOINTMENTS:

See attached Communications Policy.

COUNSELOR-CLIENT PROFESSIONAL RELATIONSHIP:

My priority is to provide safe and ethical care and counseling for each client. For this reason, the counselor-client relationship is professional rather than personal in nature. I will hold clearly defined professional boundaries. This means that sessions will focus exclusively on your concerns. Romantic and sexual relationships are specifically prohibited. Please refrain from giving invitations to social gatherings, offering gifts of any kind, or asking for written references for yourself. If we find ourselves in the community or at a social gathering at the same time, please know that I will respect your privacy. This means that I will not make contact with you or acknowledge the professional relationship, unless you initiate or such contact is unavailable and awkward if not made. I am not ignoring you, but I want to protect your privacy. These professional boundaries are for your own safety and privacy.

Please be aware of the following information concerning all iHope staff and counselors:

- We are not available 24 hours a day. In a crisis, please call 911 for emergency help.
- We are not physicians and cannot prescribe medications or give medical advice.
- We cannot guarantee treatment success or provide a prediction of the length of counseling, given that each client presents unique strengths and struggles.
- We will follow all state and federal laws, as well as the iHope Policies and Procedures.
- We are Christians and affirm the iHope statement of faith. You can review this on our website or in the front office. Clients are not required to affirm this statement of faith.
- We will treat you with respect and dignity in every interaction. If needed, you are welcome to file a grievance with the front office. This will not impact your quality of care.

CONSENT TO TREAT:

By your signature below, you indicate you have read and understood this statement, and any questions about this statement were answered to your satisfaction. You also indicate that you have received a copy of this statement for your records. *All members of your family who are involved in this counseling service must sign below to indicate understanding and agreement.*

Client Signature: _____ Date: _____
Print Name

Please complete if client is under 18:

Parent/Guardian Signature: _____ Date: _____
Print Name

With my signature below, I, Kevin Deas, MA, LPCA verify the accuracy of this statement and acknowledge my commitment to its specifications.

Signature _____ Date: _____