CLIENT CONSENT FORM
ADE, Inc
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IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You, ADE, Inc and Dr. Ireland have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

AVAILABLE SERVICES: ADE, Inc (Altering Disordered Eating) offers individual counseling services. Martha Ireland, PhD, RN, MC, CEDS is a doctor of pastoral psychology, a licensed psychiatric clinical nurse specialist, and a certified eating disorder specialist. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. Please direct any questions or concerns you may have to Dr. Ireland.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, specific problem solving and desired behaviors changes. Dr. Ireland cannot guarantee these benefits, of course. It is her desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: Your first visit will be an assessment session in which you and Dr. Ireland will determine your concerns, and if both agree that Dr. Ireland can help facilitate you meeting your therapeutic needs, then another session will be scheduled. It may take up to 3 sessions to develop a complete plan of treatment. Should you choose not to follow the plan of treatment provided to you by Dr. Ireland, services to you may be terminated.

The goal of ADE, Inc is to provide the most effective therapeutic experience available to you. If at any time you feel that you and Dr. Ireland are not a good fit, please discuss this matter with her to determine if transferring to a more suitable Therapist is right for you. If you and Dr. Ireland decide that other services would be more appropriate, she will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. ADE, Inc and referrals to other adjunct disciplines are designed to provide ADE, Inc clients with an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by Dr. Ireland. If you must cancel or reschedule your appointment, we ask that you call our office at 703-722-2324 at least 24 hours in advance or you will be responsible for the full fee of the scheduled appointment. Insurance companies do not provide reimbursement for missed appointments.

FEE SCHEDULE:	Diagnostic & Evaluation Session (1st Visit)) :	$265.00
	Regular session onsite or virtual (50 minutes):	$175.00
	Sessions lasting longer are pro-rated at $175/50 minutes	
	Clinical phone calls and emails pro rated at:	$175/hr
	Written Reports (insurance companies, supervisors, etc. pro-rated at:	$175.00/hr

Returned check fee per check $35.00
A reasonable fee will be charged for copies of any records requested by the Client.

PAYMENT/INSURANCE FILING: Payment of fees is expected at the time of each appointment. ADE, Inc request that payment be made before your session begins. ADE, Inc does not bill insurance companies, and expects full payment at the time of service. You may also pay online, with pay pal, at www.irelandphd.com prior to your appointment. Please bring a print-out, showing verification of payment made to your scheduled session. ADE, Inc. will provide you with a monthly statement for services rendered. The monthly statements may be used by the client to file with their own insurance company. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact the office regarding the nature and urgency of the circumstances. Dr. Ireland will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, Dr. Ireland or a staff member will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours or on a weekend, or you are unable to wait for a return call, please follow the directions on the office voice mail. If you are experiencing a life-threatening emergency, call 911, or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: ADE, Inc follows all ethical standards prescribed by state and federal law. ADE, Inc is required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between Dr. Ireland and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where Dr. Ireland has a duty to disclose, or where, in Dr. Ireland's judgment, it is necessary to warn or disclose; fee disputes between ADE, Inc and the client; a negligence suit brought by the client against ADE, Inc and/or Dr. Ireland; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of Dr. Ireland where you and she can discuss this matter further. By signing this Information and Consent Form, you are giving consent to ADE, Inc and Dr. Ireland to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless ADE, Inc and Dr. Ireland from any departure from your right of confidentiality that may result.

CONFIDENTIALITY OF EMAIL, CELL PHONE, AND FAX COMMUNICATIONS: Therapeutic encrypted emails are accessed by registering at www.VirtualTherapyConnect.com and completing the connection process for Dr. Martha Ireland. You must be registered at Virtual Therapy Connect, in order to send or receive encrypted mails with Dr. Martha Ireland. No other encrypted service will be accepted at this time. If you choose to email me from your personal email service, please be aware that regular email services are not secure and should be limited to non therapeutic issues such as re-scheduling and 24 hour notice cancellations. I will not respond to personal and/or clinical concerns via regular email. Emails used to share or journal between sessions need to be sent via Virtual Therapy Connect encrypted email system. I may not have the opportunity to review your entries until our next scheduled session, but if I do respond with an email between sessions containing confidential information, that information will be sent through the Virtual Therapy Connect encrypted email system. If you call me, please be aware that unless we are both on land line phones, the communications are not considered secure or confidential. Likewise, text messages are not secure or confidential. If you send a fax to me, my fax is in a secure location. Please be sure that you have completed and signed the ADE permission to contact form.

DUTY TO WARN/DUTY TO PROTECT: If Dr. Ireland believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to ADE, Inc and Dr. Ireland to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to ADE, Inc, and Dr. Ireland to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name: Telephone Number :

_____ _____

_____ _____

_____ _____

_____ _____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of Dr. Ireland, it will be necessary to refer my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, recommended by Dr. Ireland or ADE, Inc, to take possession of my records and deliver those records to the recommended therapist and/or another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, ADE, Inc. and Dr. Ireland will not render services to your child until the she has received and reviewed a copy of the most recent applicable court order.

_____ _____

Signature—Client/Parent Date

_____ _____

Signature—Spouse/Partner/Parent Date

_____ _____

Martha Ireland PhD, RN, CS, CEDS Date

I hereby authorize the release of necessary medical information/records for continuity of care.

_____ _____

Client/Parent Date