Jon Schoonmaker, MA, LPC

Omega Youth Empowerment, PLLC

600 N. Broad St.

Adrian, MI 49221

**Phone: (517)902-1754** [**jon@liveOmega.net**](mailto:jon@liveOmega.net)

**INFORMATION AND CLIENT CONSENT for a MINOR**

The following information will be discussed with you at your child’s first session.

**CLIENT/THERAPIST RELATIONSHIP**: Your child and I will establish a therapeutic relationship based on mutual respect and care that exist exclusively for the benefit of your child. If your child chooses to participate in youth empowerment programming offered through my practice, clear boundaries will be maintained to protect his/her privacy.

**COUNSELING**: I am a skilled and experienced Licensed Professional Counselor and Youth Worker. Effective counseling is founded on mutual understanding and good rapport between client and therapist. I provide short-term, brain-change interventions designed to address problematic life issues. Your child’s first visit will be an assessment session in which concerns will be identified, and if appropriate, a plan of treatment will be developed.

If at any time you feel that your child is NOT benefitting from counseling, please discuss this matter with me to determine if a referral to a more suitable therapist is right for your child. If the decision is made that other services would be more appropriate, you will be assisted in finding a provider to meet your needs.

Through the ongoing integration of physical, emotional, mental, and spiritual awareness, each person has the opportunity to create and preserve a whole and happy life. My counseling services are designed to provide clients with an integrated approach that addresses emotion, mind, body and spirit to provide healing and enhancement for their lives. Please note that spiritual awareness in the counseling process is about a connection to a Loving Higher Power – whatever that might be for an individual. I do not promote any specific religious doctrine but encourage clients to explore what a connection to a Loving Higher Power means for them.

**RISKS AND BENEFITS**: Counseling is beneficial, but as with any treatment, there are inherent risks. During counseling, your child will explore personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling typically far outweigh any discomfort encountered during the process. These benefits cannot be guaranteed, but I will work with your child to attain the personal goals established.

**APPOINTMENTS & CANCELATIONS**: 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. If you must cancel or reschedule your child’s appointment, you are requested to call/text Jon Schoonmaker at (517)902-1754 or email him at [jon@liveomega.net](mailto:jon@liveomega.net) at least 24 hours in advance, whenever possible. This will free your appointment time for another client. **If an appointment is cancelled within 24 hours of the scheduled time, not because of an emergency or illness, the parent will be responsible for the full session fee.**

**NO SHOWS.** If a client does not show up for a regularly scheduled appointment and does not make contact with me to reschedule on 3 separate occasions or 2 consecutive occasions, the client will be removed from the schedule. It is the responsibility of the parent/guardian of the client to make sure the client is at scheduled appointments.

**PAYMENT/INSURANCE FILING:** Payment of fees is expected at the time of each appointment. Payment may be made in the form of cash, check or credit card. Clients will be provided with a Superbill for services rendered that may be used to obtain reimbursement from insurance. Currently, Both Meridian Health Plan and Blue Cross Blue Shield of Michigan are accepted insurance plans.

A reasonable fee will be charged for copies of any records requested by the client.

A sliding scale is may be arranged based on the financial needs of the client.

**SESSION EXPECTATIONS FOR PARENTS**: A parent, or other responsible adult, must remain in the waiting area while a child under the age of 12 is participating in a therapy session unless otherwise previously agreed upon. Parents will often be invited into the counseling room at the beginning or the end of a minor child’s session to give an overview of “how things are going at home.” Parents are encouraged to email me at [jon@liveomega.net](mailto:jon@liveomega.net) prior to sessions with information that might be helpful for the session. Confidentiality ethics are maintained at all times (see below).

**CONFIDENTIALITY:** I adhere to all ethical standards prescribed by state and federal law. Standards of care require that records of your counseling be maintained. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a therapist 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 the Therapist has a duty to disclose, or where, in the Therapist’s judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board.

By signing this Information and Consent Form, you are giving consent me to share confidential information with all persons mandated by law, with the agency that referred your child and the insurance carrier responsible for providing your child’s mental health care services and payment for those services. You are also releasing me and holding me harmless from any departure from your right of confidentiality that may result.

**ADOLESCENT AND PARENT CONFIDENTIALITY**

In order to facilitate honesty and openness in the counseling session, I ask the parents/guardians of adolescents to respect their child’s privacy and to avoid pressuring your child to disclose the content of counseling sessions.

Confidentiality is my responsibility and promise to the adolescent. The adolescent is always free to share the content of a counseling session with whomever he/she desires.

If a non-safety issue arises in the counseling session with an adolescent that might be helpful for the parents/guardians to be aware of, I will work with the adolescent find an appropriate way to disclose.

I respect, support, and encourage parents/guardians to be actively involved in the therapeutic work of their adolescents. I ask parents/guardians to share with me any concerns and the outcomes of therapy in the home environment on a regular basis.

**OMEGA YOUTH EMPOWERMENT PROGRAM PARTICIPATION:** Students are welcomed and encouraged to participate in empowerment and therapeutic programming/events offered by Omega Youth Empowerment and Wolakota Youth Programs. These programs are supervised by me and my interns and Wolakota staff. Individual therapeutic confidentiality will be maintained in all program experiences. Participation in empowerment and therapeutic programming is open to clients as well as to teens from the general public. There is no prerequisite for participation in empowerment and therapeutic programming. The privilege of participation in programming is retained as long as the client’s program participation remains appropriate.

**EMERGENCIES**: You and your child may encounter a personal emergency which will require prompt attention. In this event, please contact me at (517)902-1754 regarding the nature and urgency of the circumstances. Every attempt will be made to schedule an appointment 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, every effort will be made to respond to your emergency in a timely manner. If your child is experiencing a life-threatening emergency, call 911 or have someone take him/her to the nearest emergency room for help. You will be advised when I am out of town.

**DUTY TO WARN/DUTY TO PROTECT**: If I believe that your child is in any physical or emotional danger, or that your child may injure another human being, I am obligated by law to warn and protect. I am required to contact any person, including medical or law enforcement personnel, who is in a position to prevent harm to your child or another, including, but not limited to, the person in danger.

**INCAPACITY OR DEATH**: In the event that it becomes necessary for another therapist to assume possession of your child’s treatment records, this will occur with your full knowledge and participation.

**CLIENT RIGHTS**

Concerns, questions, or complaints regarding my counseling practice may be directed to:

Michigan Department of Licensing and Regulatory Affairs

Enforcement Division  
 Allegations Section

PO Box 30670

Lansing, MI 48909

(517)373-9196

**CONSENT TO TREATMENT BY THE GUARDIAN**: By signing this form as the parent/guardian of the minor client indicated below, I attest that I am his/her legal guardian. I acknowledge that I have read, understand, and agree to the terms and conditions contained here-in. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I voluntarily agree for my child to receive mental health assessments, treatment, and services, and I understand that I may stop such treatment or services at any time.

In consideration for the services provided to my child I fully release Jon Schoonmaker, LPC from any claims and demands that might arise, or be incident to the evaluation and/or treatment of my child, provided that his duties are performed with standard care and responsibility to the best of his professional ability.

Name of Client (please print) Date of Birth

Name of Parent/Guardian (please print)

Signature – Parent/Legal Guardian Date

Jon Schoonmaker, LPC Date