INFORMED CONSENT FORM

I, _____ hereby consent to receiving Counselling and Therapy with Illumine, as a Client with the following understandings:

MENTAL HEALTH SERVICES

Illumine recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help, the Client will be better able to understand their situation and feelings and will be able to move toward resolving their difficulties. The therapist will strive to help the Client grow toward greater health and wholeness by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our therapists work within the context of each individual's beliefs, and no attempt is made to impose a personal theology.

THERAPIST/COUNSELLOR

The therapist is a licensed professional engaged in providing mental health care services to clients directly as an employee of Illumine. The therapist has discussed with Illumine the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. The Client may withdraw from treatment at any time, but please discuss this with the therapist.

APPOINTMENTS AND CANCELLATIONS

Mode of Appointment:

Appointments are made through Whatsapp, by messaging the contact number, +91 9632625046, Monday through Friday between the hours of 5:00 am and 11:30 pm, IST. All appointments will be verified only once confirmation of payment for the session is provided.

Cancellation by Counsellor/Therapist:

In the event of personal constraints, family-related emergencies, health conditions, and other such unavoidable situations, the Counsellor/Therapist reserves the right to cancel a pre-booked session before it commences. In case of such an event, the booked session will get rescheduled to another slot at no cost, with the consent of the client. If the Client decides to withdraw from the session in case of such an event, the entire amount paid for the session will be refunded.

The Counsellor/Therapist reserves the right to cancel the Client's appointment in the event of any of the following situations:

A. If the Client has withheld medical-related information, or lied or provided misinformation regarding the same.
B. If the Client does not revert back within 10 days of the previous session to schedule a following appointment.
C. If the Client uses abusive language, or displays aggressive behaviour towards to the Counsellor/Therapist or any member of staff, permanent or contractual of the consultancy firm, Illuminne.
D. If the Counselling and Therapy session's goals are met.

Cancellation by Client:
The Client has the right to withdraw from the Counselling and Therapy Sessions at any point of the session, or sessions. Such withdrawal must be accompanied by a 'Letter of Withdrawal' from the Counselling and Therapy Sessions, emailed to infodranisha@gmail.com within 24 hours of the act of discontinuation or cancellation of the sessions by the Client.

In the event that the Client cancels a session, the booked session will be rescheduled to another slot, at no additional cost. However, in the event of a third consecutive cancellation, the firm reserves the right to cancel the session and it's rescheduling without any refund.

NUMBER, LENGTH AND MODE OF SESSIONS
Number and Length Of Sessions:
Illumine mandates a minimum of 3 sessions, spread across a period of 30 days. The length of each Therapy/Counselling session may range from [30] minutes to [50] minutes.

Mode/Format of Session:
The Session will take place in an ONLINE Audio Call format, unless the Therapist/Counsellor suggests for an OFFLINE - Face to face session format, or ONLINE Video call format. The Client can enquire about the same, during the process of the booking of a session.

RELATIONSHIP
The Client's relationship with the Therapist/Counsellor is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the Therapist/Counsellor does not have any other type of relationship with the Client.

Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The Therapist/Counsellor cares about helping the Client but is not in a position to be a friend or to have a social and personal relationship with the Client. Gifts, bartering, and trading services are not appropriate and should not be shared between the Client and the Therapist/Counsellor.

CONFIDENTIALITY
Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law, or listed under the following exceptions.

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, notify, or disclose; fee disputes between Therapist/Counsellor and the Client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority.

Additionally, the Consultancy Firm, Illumine, and the Counsellor/Therapist reserve the right to:

A. Make use of relevant case information (withholding personal details and demographic details) for research purposes.
B. Publish and present the Client's Therapy/Counselling session(s) as relevant example(s) for academic purposes.

If the Client has any questions regarding confidentiality, they should bring them to the attention of the Therapist/Counsellor when the Client and the Therapist discuss this matter further.

By signing the Informed Consent Form, the Client is giving his/her consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred the Client, and the managed care company and/or insurance carrier responsible for providing the Client's mental health care services and payment for those services. The Client is also releasing and holding harmless the Therapist/Counsellor from any departure from the Client's right of confidentiality that may result.

RISKS OF THERAPY

Therapy is the Greek word for change. Clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy.

PAYMENT FOR SERVICES

All sessions are required to be paid for by the Client, at the time of booking of the session, via an Online Bank Transfer, or utilizing the said payment gateway, Google Pay, Paytm, or Paypal. The Session fees will be inclusive of taxes, and have no additional or hidden costs for the session.

In the event that the Money is not paid 12 hours prior to the session commencing, the Counsellor/Therapist reserves the right to cancel the session, or terminate the case without any refunds.

Information regarding refunds:

A. In the event of the Counsellor/Therapist cancelling the session, and the Client deciding to withdraw, the amount paid for the session in question will be refunded.
B. In the event of a Client rescheduling a session, and then cancelling the same, the amount paid for the session in question will not be refunded.
C. Money paid through International Transactions and banking systems will be refunded after the deduction of transaction costs and taxes.

COURT

Although it is the goal of the Therapist/Counsellor to protect the confidentiality of the Client's records, there may be times when disclosure of the Client's records or testimony will be compelled by law. In the event that disclosure of the Client's records or the therapist's testimony are requested by the Client or required by law, the Client will be responsible for and shall pay the costs involved in producing the records and the Therapist's normal hourly rate for giving that testimony. Such payments are to be made at the time prior to the time the services are rendered by the Therapist/Counsellor.

THERAPIST/COUNSELOR'S INCAPACITY OR DEATH

In the event the Therapist/Counsellor becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing the Informed Consent form, the Client gives his/her consent to another licensed mental health professional at Illumine to take possession of the Client's files and records and provide the Client with copies upon request, or to deliver them to a therapist of the Client's choice.

CONSENT TO TREATMENT

By signing the Informed Consent form, the Client voluntarily agrees to receive mental health assessment, care, treatment, or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that the Client understands and agrees that the Therapist/Counsellor will participate in the planning of your care, treatment, or services, and that the Client may stop such care, treatment, or services at any time. By signing the Informed Consent form, the Client acknowledges that he/she has both read and understood all the terms and information contained herein. Ample opportunity has been offered for the Client to ask questions and seek clarification of anything that remains unclear.

CONTACT INFORMATION

By signing the Informed Consent form, the Client is consenting for Illumine to communicate with them by mail, e-mail, and phone at the address and phone numbers provided at the initial appointment, and the Client will immediately advise Illumine in the event of any change. The Client agrees to notify Illumine if they need to opt out of any form of communication.

NAME OF CLIENT:

SIGNATURE OF CLIENT: **DATE:**

SIGNATURE OF ILLUMINE STAFF: **DATE:**

ADDENDUM FOR CHILD/ADOLESCENT PATIENT

PARENT AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify Illumine immediately. Further, Illumine requires a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child.

If you are separated or divorced from the child's other parent, please be aware that it is policy to notify the other parent that I am meeting with your child. It is important that all parents have the right to know, unless there are truly exceptional ccircumstances, that their child is receiving mental health evaluation or treatment.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the Therapist/Counsellor regarding the child's treatment. If such disagreements occur, the Therapist/Counsellor will strive to listen carefully so that the Therapist/Counsellor can understand your perspectives and fully explain their perspective. Such disagreements are encouraged to be resolved in order to further the child's therapeutic progress.

Ultimately, parents decide whether therapy will continue. If either parent decides that therapy should end, the Therapist/Counsellor will honor that decision, unless there are extraordinary circumstances. However, in most cases, the Therapist/Counsellor will ask that you allow them the option of having a few closing sessions with your child to appropriately end the treatment relationship.

INDIVIDUAL PARENT/GUARDIAN COMMUNICATIONS WITH THE THERAPIST/COUNSELLOR

In the course of my treatment of your child, the Therapist/Counsellor may meet with the child's parents/guardians either separately or together. Please be aware, however, that, at all times, the patient is your child – not the parents/guardians nor any siblings or other family members of the child. If the Therapist/Counsellor meets with you or other family members in the course of your child's treatment, they will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

MANDATORY DISCLOSURES OF TREATMENT INFORMATION

In some situations, the Therapist/Counsellor is required by law or by the guidelines of my profession to disclose information, whether or not they have your or your child's permission. Some of these situations are listed below.

Confidentiality <u>cannot be maintained</u> when:

- Child patients tell the Therapist/Counsellor that they plan to cause serious harm or death to themselves, and the Therapist/Counsellor believes they have the intent and ability to carry out this threat in the very near future. The

Therapist/Counsellor must take steps to inform a parent or guardian or others of what the child has told me and how serious they believe this threat to be and to try to prevent the occurrence of such harm.

- Child patients tell the Therapist/Counsellor they plan to cause serious harm or death to someone else, and the Therapist/Counsellor believes they have the intent and ability to carry out this threat in the very near future. In this situation, Illuminne must inform a parent or guardian or others, and also may be required to inform the person who is the target of the threatened harm [and the police].

- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, the Therapist/Counsellor will need to use their professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell the Therapist/Counsellor, or they otherwise learn that, it appears that a child is being neglected or abused (physically, sexually or emotionally) or that it appears that they have been neglected or abused in the past. In this situation, the Therapist/Counsellor [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.

- The Therapist/Counsellor, or the Consultancy Firm, Illumine are ordered by a court to disclose information.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is Illuminne's policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm. However, if your child's risk-taking behavior becomes more serious, then the Therapist/Counsellor will need to use their professional judgment to decide whether your child is in serious and immediate danger of harm. If the Therapist/Counsellor feels that your child is in such danger, they will communicate this information to you.

Example: If your child tells me that they have tried alcohol at a few parties, I would keep this information confidential. If you child tells me that they are drinking and driving or is a passenger in a car with a driver who is drunk, I would not keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I would not keep that information confidential.

Example: If your child tells me that they are having voluntary, protected sex with a peer, I would keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I will not keep this information confidential.

You can always ask the Therapist/Counsellor questions about the types of information they would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that they were doing _____, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, the Therapist/Counsellor may believe that it is important for you to know about a particular situation that is going on in your child's life. In these situations, the Therapist/Counsellor will encourage your child to tell you, and they will help your child find the best way to do so.

Aadditionally, when meeting with you, the Therapist/Counsellor may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

DISCLOSURE OF MINOR'S TREATMENT RECORDS TO PARENTS

Although the laws of [this State] may give parents the right to see any written records the Therapist/Counsellor keeps about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

<u>Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation</u>

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although the Therapist/Counsellor's responsibility to your child may require their help to address conflicts between the child's parents, the Therapist/Counsellor's role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena my records or ask me to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that your agreement may not prevent a judge from requiring the Therapist/Counsellor's testimony, even though they will not do so unless legally compelled. If the Therapist/Counsellor is required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, the Therapist/Counsellor will provide information as needed, if appropriate releases are signed or a court order is provided, but will not make any recommendation about the final decision(s). Furthermore, if the Therapist/Counsellor is required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for their participation agrees to reimburse the Therapist/Counsellor at the

rate of _____ per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

CONSENT AND AGREEMENTS
Child/Adolescent Patient

By signing below, you show that you have read and understood the policies described above. If you have any questions as we progress with therapy, you can ask the Therapist/Counsellor at any time.

Minor's Signature* **_____** **Date_____**

Parent/Guardian of Minor Patient

Please initial after each line and sign below, indicating your agreement to respect your child's privacy:

The Therapist/Counsellor will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

_____
_____

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my child's/adolescent's treatment.

_____
_____

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the Therapist/Counsellor's professional judgment, unless otherwise noted above.

_____
_____

Parent/Guardian Signature _____
Date_____

Parent/Guardian Signature _____
Date_____

* For very young children, the child's signature is not necessary