

## INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES & OFFICE POLICIES

**This form provides you (client) with information that is additional to that detailed in the Notice of Privacy Practices. Please initial each paragraph in the space provided indicating that you have read and understood the content of that paragraph.**

**CONFIDENTIALITY:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure are described to you in the Notice of Privacy Practices.

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**When Disclosure Is Required By Law:** Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; and where a client presents a danger to self, to others, or is gravely disabled (see also Notice of Privacy Practices form).

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**When Disclosure May Be Required:** Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. I will not release records to any outside party unless they are authorized to do so by **all** adult family members who were part of the treatment.

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**Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be highly sensitive and of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you, nor your attorney, nor anyone else acting on your behalf will call on me to testify at any proceeding, nor will a disclosure of the psychotherapy records be requested.

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**Health Insurance & Confidentiality of Records:** Disclosure of confidential information may be required by your health insurance carrier, HMO/PPO/MCO/EAP, or other third party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the psychotherapy notes will not be disclosed to your insurance carrier. I have no control or knowledge over what insurance companies do with the information they submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information, including diagnosis, is entered into insurance companies' computers and

will also be reported to the congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

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**Confidentiality of Email, Cell Phone and Faxes Communication:**

It is very important to be aware that email and cell phone communication can be relatively easily accessed by unauthorized people and hence, the privacy and confidentiality of such communication can be compromised. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. My emails are not encrypted, and emails and faxes can easily be sent erroneously to the wrong address. If you communicate confidential or private information via email, I will assume that you have made an informed decision and view it as your agreement to take the risk that such communication may be intercepted. Emails are part of the medical records. Please notify me at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Please do not use email or faxes for cancellations or emergencies.

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**Safeguarding of Records:**

I have a duty to protect client confidentiality. Clinical records contain Protected Health Information (PHI) covered by both state and federal confidentiality laws. I am required to safeguard the information in these records against loss, damage, tampering, or use by unauthorized persons. All client information is stored in a "double locked" manner (i.e. in a locked filing cabinet within a locked office).

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**Consultation:** I may consult with other professionals regarding their patients; however, the patient's name or other identifying information is never mentioned. The patient's identity remains completely anonymous and confidentiality is fully maintained. This is done to provide you with the best care possible.

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**THE PROCESS OF THERAPY:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Psychotherapy requires your very active involvement, honesty, and openness in order to change. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. During therapy, remembering or talking about painful memories, unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings. This may include anger, sadness, worry, fear, shame, anxiety, depression, insomnia, etc. I may challenge some of your assumptions and/or perceptions and propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing perceptions, beliefs, behaviors, employment, substance use,

schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. Sometimes more than one approach can be helpful in dealing with a certain situation. These approaches may include, but are not limited to: cognitive-behavioral, psychodynamic, mindfulness-based therapies, behavioral, systems/family of origin, developmental (adult, child, family), biblio-therapy, or psycho-educational.

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**Discussion of Treatment Plan:** Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about the course of your therapy, the possible risks, my ability, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

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**Termination:** You have the right to terminate therapy at any time. Ideally, this happens when the goals of therapy have been met. If at any point during psychotherapy, I believe that I am not effective in helping you reach the therapeutic goals, I am obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the new psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and with your written consent will provide her or him with the essential information needed.

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**Dual Relationships:** A dual relationship exists when you have some type of relationship with your therapist outside the clinical setting. This may include civic and philanthropic groups, religious communities, sports leagues, etc. For the best possible outcome and care of your treatment, you and I will refrain from engaging in any type of dual relationship. Therapy NEVER involves sexual or any other dual relationship that can be exploitative in nature, or impairs my objectivity, clinical judgment and/or therapeutic effectiveness.

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**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact me between sessions, please leave a message on my voicemail and your call will be returned as soon as possible. All urgent calls will be returned within 24 hours. Understand that I may charge you for services rendered over the phone. Please clarify with me about the policy in this regard. If an emergency situation arises, please indicate it clearly in your message. *In case of an emergency, or when there*

is immediate danger or potential for harm, call 911. Initial \_\_\_\_\_

**PAYMENTS:** Clients are expected to pay the standard fee of \$150.00 for the initial assessment, and \$125.00 per 50 minute session, at the beginning of each session. Telephone conversations, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, etc. will be charged at the same rate, unless indicated and agreed otherwise. Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments. Initial \_\_\_\_\_

**INSURANCE:** I do accept some health plans. Health insurance is a contract between you and your insurance company. **Clients who carry insurance are responsible for a copay and for obtaining authorizations required for treatment.** As was indicated in the section *Health Insurance & Confidentiality of Records*, be aware that submitting a mental health invoice to your insurance carrier for reimbursement carries a certain amount of risk. Not all issues/conditions/problems which are the focus of psychotherapy are reimbursed by insurance companies; it is your responsibility to *verify* the specifics of your coverage. **You are still responsible for all fees not paid by your insurance company.**

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**I have read the above Informed Consent for Psychotherapy Services & Office Policies carefully; I understand them and agree to comply with them.**

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(Signature)

(Date)

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(Signature of Parent or Guardian)

(Date)