

# Informed Consent

Welcome to \_\_\_\_\_ . This Informed Consent document contains important information about my professional services and business policies. Please read carefully and ask questions you may have. When you sign this document, it will represent an agreement between us.

**PSYCHOLOGICAL SERVICES:** Psychotherapy varies depending on your needs and particular problems you hope to address. There are many different methods I may use to address problems/concerns/issues. Psychotherapy calls for an active effort on your part. In order for therapy to be successful, you will need to work on things we talk about both during our sessions and at home.

Clients often learn things about themselves that they don't like during sessions. Often growth cannot occur until past issues are experienced and confronted, which can cause 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 and changes that may result from therapy.

I will conduct an initial evaluation. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If not, I will provide you referrals to other practitioners whom I believe are better suited to help you. If you have questions about my techniques, we should discuss them whenever they arise.

## CLIENT RIGHTS:

- Be treated with dignity and respect
- Know the qualification and professional experience of your therapist
- Privacy and confidentiality
- Ask questions regarding your treatment
- Know information regarding diagnosis, treatment philosophy, method, progress, and prognosis
- Participate in decisions regarding your treatment
- Know assessment results and have them explained to you in a manner that you understand
- Refuse treatment methods or recommendations
- End counseling at any time (please discuss reason for wanting to end counseling)

## CLIENT RESPONSIBILITIES

- Maintain your own personal health and safety
- Take an active role in the therapeutic process to include honestly sharing thoughts, feelings, and concerns
- Help plan your goals
- Follow through with agreed upon goals
- Provide accurate information regarding past and present physical and psychological problems
- Keep scheduled appointments.

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**PROFESSIONAL FEES:** My hourly fee is . If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need. Other professional services include report writing, telephone conversations, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party.

**BILLING AND PAYMENTS:** You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I will release regarding a client's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

**CANCELLATION POLICY:** Once an appointment is scheduled you will be required to pay for that appointment at the fee set for the length or purpose of the appointment unless 1 full business day notice is provided (a Monday morning appointment must be canceled by Friday morning). Cancellations with less than 24 hours notice will be charged the full session fee. I do understand that circumstances beyond your control can arise. In specific cases the fee may be waived at my discretion. Excessive missing of appointments, whether paid or unpaid, will result in a reevaluation of our contract and your continuation in therapy. Please note that consistency in counseling, and attending each session will provide you with the optimum potential to benefit from your therapeutic experience.

**INSURANCE REIMBURSEMENT:** Should you elect to utilize health insurance for services received, be aware that often insurance and managed care companies require information regarding diagnosis, symptoms, treatment goals, and prognosis about the insured before reimbursement is ever considered by them. Such companies may also request a copy of your records. When utilizing faxes, electronic communication devices and web-based records management systems, there is always a level of vulnerability that may not be preventable despite all safeguards that have been put in place.

**CONTACTING ME:** I am often not immediately available by telephone. I will usually not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voicemail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If I will be unavailable for an extended time, I will provide you with the name of another counselor to contact.

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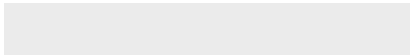
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**EMERGENCIES OR CRISES:** I will check email and voicemail and will return your call at my earliest opportunity. If you are unable to reach me, or if you have a life-threatening emergency, immediately call 911, or go to a hospital emergency room. Your safety and well-being is my primary concern.

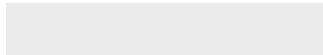
**CONFIDENTIALITY:** Discussions between a therapist and a client are confidential. No information will be released without your written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: (can vary by state)

- Abuse and neglect of children
- Abuse neglect of elderly or dependent adult
- Danger to self or others
- Court orders
- Professional misconduct
- National Security Investigations

**CONSENT TO TREATMENT:** By signing the Informed Consent, you voluntarily agree 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 you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment, or services at any time.



Signature



Date