Informed Consent and Authorization for Psychotherapy

PAYMENT/FEES

Paying for therapy is often a very sensitive topic, and we can discuss your concerns about payment as needed. The law requires that all fee(s) are established and agreed to before we can begin. This section clarifies all fees, and defines your financial responsibilities:

1. If I am in network with your insurer – I will bill them directly as a courtesy to you. They will determine the amount that is reimbursed to me based on your plan/coverage. You will be responsible for those costs related to your deductible and copays or co-insurance costs.

2. If I am not in network with your insurer – you will be charged $200 for every 60 minute session and I will provide you with a receipt so you can submit for possible reimbursement. You will be solely responsible for checking to see if you have out of network benefits and for submitting the receipt.

3. Canceling or rescheduling appointments requires a (24) hour notice by telephone to avoid being charged. Given insurance does not cover costs if you miss an appointment – you will be responsible for the cost of the time you reserved.

4. Written reports of any type are billed to you at $130.00/hour…this is not covered by insurance. Also appearing at meeting(s) or legal proceedings on your behalf is not covered by insurance, and is billable to you at $130.00/hr. for the entire time spent away from the office.

5. My office does not process credit cards or debit cards. All payments are due at time of session and are payable by cash or check only. I do not offer payment plans.

Your initials here agreeing to the 'Payment of Fees': _____

CONFIDENTIALITY LIMITS AND EXCEPTIONS

1. Normally, everything we discuss will be held confidential. Unless you provide a signed authorization, I will not speak to or correspond with anyone about you.

2. If you choose to break confidentiality in any way I cannot control, or be held liable for the outcome.

3. Law and professional ethics either mandate or permit therapists to break client confidentiality under certain circumstances.

Some exceptions to confidentiality include situations in which there is reasonable suspicion that any of the following has ever occurred or is occurring now:

- **you or your child present a danger to self or others**
- **a child or dependent adult is the victim of emotional, sexual or physical abuse, neglect or unjustified mental suffering**
- **a dependent adult or any person over the age of 65 years is the victim of physical abuse, emotional abuse, abandonment, forced isolation, fiduciary abuse, or neglect**

Your initials here agreeing to 'Confidentiality Limits & Exceptions': _____

MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL EVALUATIONS

1. If medical, psychiatric and/or psychological evaluation seems warranted, we will discuss the nature of these evaluations and appropriate referrals will be provided. If the need for evaluation(s) by other professionals is established and you do not follow these recommendations, your therapy may necessarily be suspended or terminated.

2. Certain medications that ease emotional suffering may be prescribed by a licensed physician or APRN before or during your course of treatment. If you are already taking prescribed medications or, if you begin medication while receiving psychotherapy, your medication compliance will be a condition of treatment.

3. For coordination of treatment you may be asked to sign a consent for release of records from any provider that can be helpful to your care. You have a right to not approve/sign such consent however it is most helpful for your continued care if you do agree to have your records transferred to my office.

Your initials here agreeing to 'Medical, Psychiatric & Psychological' conditions:

_____

LIMITS OF COMMUNICATION

1. Every effort will be made to assist you, especially during crisis. However, there may be times when contacting you won't be possible. Therefore, you must agree to first call 911 or go to the nearest hospital Emergency Room for assistance, any time that you suspect you are in crisis.

2. As a standard business practice, each appointment ends (60) minutes from the scheduled start of the appointment, regardless of your arrival time. I am not able to extend sessions since other clients may be waiting.

3. Correspondence sent to this office is retrieved at random, and several days may go by before mail is retrieved.

4. **I do not receive texts** on my office phone (203) 663-0233. Calls are retrieved from my voicemail at several times during the day at random intervals. If you wish I return your call make sure 'Call-Blocking' is turn off as my number will usually appear private.

5. I maintain very firm personal boundaries. I reserve the right to terminate treatment if, for any reason, a client obtains my home telephone phone number or my residential address.

Your initials here agreeing to 'Limits of Communications': _____

TREATMENT TERMINATION

1. If at any time during the course of your treatment I determine I cannot continue, I will terminate treatment and explain why this is necessary. Ideally, therapy ends when we agree your treatment goals have been achieved. Additional conditions of termination include:

2. You have the right to stop treatment at any time. If you make this choice, referrals to other therapists can be provided and you will be asked to attend a final 'termination' session.

3. Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit. If you are meeting with another therapist, you must first terminate treatment with that therapist before I can begin providing services. If you remain in therapy with someone else and this becomes apparent after we begin, I am ethically required to terminate your treatment unless of course that therapist is seeing you as an individual concurrent to your treatment with me for coupling sessions, and vice versa.

4. Other legal or ethical circumstances may arise and compel me to terminate treatment. If so, appropriate referral(s) will be offered. Also, I do not diagnose, treat, or advise on problems outside the recognized boundaries of my competencies.

5. Other situations that warrant termination include: becoming enraged or threatening during session; bringing a weapon onto the premises; arriving under the influence of drugs or alcohol; disclosing illegal intentions or actions.

Your initials here agreeing with 'Treatment Termination' conditions: _____

OFFICE ENVIRONMENT

Please do not use cell-phones, laptops or other electronic devices in the waiting area. My waiting room share the space with other health care providers – please be respectful of seating arrangements and speak in a low tone to protect your privacy as well as others. There is one flight of stairs and no elevator in my building. Parking is behind my office yet to access my office you must walk around and enter the front of the building (street entrance). NO pets and NO smoking are allowed in the building

Your initials here agreeing with 'Office Environment' conditions: _____

AUTHORIZATION TO COMMENCE PSYCHOTHERAPY

• Your signature below will verify that you have read (or that I have read to you) the information in this authorization and that you asked questions about anything you have not understood up to this point. By signing, you freely acknowledge your willingness to undergo treatment using psychotherapy methods, as I deem appropriate and in accordance with this 'Informed Consent.'

• You also agree to enter into a professional business arrangement according to all business practices outlined in this agreement. You accept total financially responsibility for payment of all fees and services as described, regardless of insurance coverage or any other 'third-party' payers.

• You will also be releasing me of any liability that directly or indirectly results from disclosure or exchange of any information covered in this agreement. At your request, a copy of this and any other document in your record that bears your signature will be provided.

_____ _____

CLIENT SIGNATURE **DATE**

_____ _____

THERAPIST SIGNATURE **DATE**