THERAPY CONSENT, POLICIES, & AGREEMENT

Patient's Name: (First) ______________________ (Middle)_______________________ (Last)____________________________

Street Address: ____ (City)___________________________

State: _________________ Zip Code: __________________________ Phone Number: __________________________________

Patient's Email Address: ____ Patient's Age: ______________________

Patient's Social Security Number: ___________________________________ Patient's Date of Birth: _______ /_______ / _______

Insurance and Primary Care Provider Information

Is the patient covered by insurance? Yes / No *If yes, please provide your insurance card to be scanned in to your file*

Insurance Policy Holder's Date of Birth: _______ /_______ / _______

Who is responsible for the bill: (First) ______________________ (Last)____________________________

Street Address: ____ (City)___________________________

State: _________________ Zip Code: __________________________ Phone Number: __________________________________

Who is your primary care provider? ____

Would you like Willowbrook Mental Health to coordinate care with your Primary Care Provider? Yes / No

Emergency Contact Information

Emergency Contact: (First) _______________________________ (Last) _________________________________
_
Relationship to Patient: __________________________ Phone Number: __________________________________

Power of Attorney/Advanced Directives and Release of Medical Information

In the state of Nebraska, it is your right to appoint an individual to make health care decisions on your behalf, would you like to be given information to appoint a medical or psychiatric power of attorney? Yes/ NO

PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaborative identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 53 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: If you are unable to keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment in advance of 24 hours of the scheduled appointment time. The only exception to this rule about cancellation is if you would endanger yourself by attempting to come (for instance, driving on icy roads), or if you or someone whose caregiver you are has fallen ill suddenly.

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment. I will tell you in advance of any anticipated absence and give you the name and phone number of the therapist who will be covering my practice during my absence.

FEES:
- Initial Session with Diagnostic Assessment - $225.00
- 60 Minute Individual Session - $185.00
- 45 Minute Individual Session - $145.00
- 30 Minute Individual Session - $100.00
- Substance Abuse Evaluation - $275.00
- Family Session - $120.00

YOUR RESPONSIBILITIES: You are responsible for coming to your session on time and at the time we have scheduled. If you are 10 minutes late, the session may be rescheduled. If you are late, we will end on time and not run over into the next person's session.

The clinician reserves the right to terminate the counseling relationship if more than three sessions are missed without proper notification.

If you no-show for two sessions in a row and do not respond to my two attempts to reschedule, I will assume that you have dropped out of therapy and will make the space available to another individual.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of: $300 per hour for phone calls, depositions, time away from office due to depositions, testimonies, and time required giving testimonies.

PHONE CONTACTS AND EMERGENCIES: Office hours are from 9:00AM to 5:00PM, Monday through Thursday. If you need to contact the clinician for any reason please call (308) 252-3179, leave a voicemail, and a return call will be made within 24 business hours or as soon as possible. In case of an emergency, you can access emergency assistance by calling or texting the National Suicide Prevention Lifeline at 988. If either you or someone else is in danger of being harmed, dial 911. You can also call Mid-Plains Crisis Stabilization Unit at (308) 358-5250 or 1-800-515-3326.

PART II: CONFIDENTIALITY:

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.

- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when a your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical records.

- **Electronic Communication:** If you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

If you elect to text message me please be aware that texting is not completely confidential. I have a HIPAA compliant phone number through Spruce Health and I will send you a request to download the app. Text messaging is only appropriate for scheduling/admin purposes in terms of your scheduled appointments. Text messages will not be answered outside the hours of 9AM-5PM Monday through Thursday.

Do not use e-mail for emergencies. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

PART III: HEALTH INSURANCE

YOUR INSURANCE COMPANY: By using insurance, I am required to give a mental health disorder diagnosis that goes in your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during the session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

If you have insurance, you are responsible for providing me with the information I need to send in your bill. You must meet your deductible at the beginning of each calendar year if it applies and any co-payment at each session. You must arrange for any pre-authorizations necessary. I will bill directly to your insurance company via electronic means for you after each session. You must provide me with your complete insurance identification information, and the complete address of the insurance company. If a check is mailed to you to cover your balance due, you are responsible for paying me that amount at the time of our next appointment. If the insurance overpays me, I will credit it to your account or refund it to you if you would prefer that.

IMPORTANT: Some psychiatric diagnoses are not eligible for reimbursement (ie: marriage/couples therapy). In the event of non-coverage or denial of payment, you will be responsible to pay for services provided. Suzanne Riley/Sara Gasper of Willowbrook Mental Health LLC/Suzanne Riley Counseling LLC/Sara Gasper Psychotherapy LLC reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.

PRE-AUTHORIZATION & REDUCED CONFIDENTIALITY: When visits are authorized, usually only a few sessions are granted at a time. When these sessions are complete, we may need to justify the need for continued service, potentially causing a delay in treatment. If insurance is requesting information for continued services, confidentiality cannot be guaranteed. Sometimes, additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not met.

FINANCIAL HARDSHIP SLIDING SCALE FEE: We can provide a sliding scale rate to any clients who qualify for our reduced rate services through hardship verification. To comply with federal regulations, in order to give a reduced rate for services, it is necessary for us to obtain income verification. You must verify your income at least every year. Your adjusted gross income is used to figure the sliding scale rate. Household adjusted gross income x .001 = Rate of session with no amount being less than $50 or higher than a regular session rate. (Ex. $45,000 per year = $50/per session, $90,000 per year = $90/per session.)

PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with Suzanne Riley/Sara Gasper/Dave Hoyt. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Suzanne Riley/Sara Gasper/Dave Hoyt to provide counseling services that are considered necessary and advisable.

2. I authorize the release of treatment and diagnosis information (as described in Part III, above) necessary to process bills for services to my insurance company, and request payment of benefits to Suzanne Riley/Sara Gasper/Dave Hoyt of Willowbrook Mental Health LLC / Suzanne Riley Counseling LLC / Sara Gasper Psychotherapy LLC / Dave Hoyt Counseling LLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, Suzanne Riley/Sara Gasper/Dave Hoyt of Willowbrook Mental Health LLC / Suzanne Riley Counseling LLC / Sara Gasper Psychotherapy LLC / Dave Hoyt Counseling LLC may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

Printed Name: ____ Date: ________ / ________ / _________

Client/Guardian Signature: ____ Date: ________ / ________ / _________