Michael R. Hemenway, MA, LMFT
1 Kingston Drive, Unit 1, Ansonia, CT 06401
203-446-6562

Informed Consent for Psychotherapy

Credentials and Experience:
Thank you for choosing Hemenway Family Therapy and Wellness, LLC for your mental/behavioral health needs. I am a Licensed Marriage & Family Therapist with my Master's Degree in Marriage & Family Therapy from Fairfield University, and a Bachelor's Degree in English from Southern Connecticut State University. I work with individuals, couples and families in a variety of different age groups and developmental life stages. I specialize in helping people manage anxiety and depression, issues related to substance use, grief and trauma issues, and navigating parent-child and/or family and couple relationships. Please review my informed consent to treatment and business policies/procedures below:

Methods of Contact:
It is preferred that all correspondence take place over the phone. Due to my schedule, I am often not immediately available. However, you are welcome to leave a voice mail message. Any correspondence that takes place via text message/email will only be used for scheduling purposes.

Please understand that in the event we encounter one another outside of session, I will not initiate acknowledgement of our therapeutic relationship unless you do so first. Please understand that I do not interact with clients on social media except for marketing purposes and this would only be done through social media accounts intended for professional use. I do not conduct crisis counseling - in the case of a medical emergency, please call 911, or in the case of an immediate need call 211 (Infoline). Please feel free to call me and leave a message to update me on the situation if you feel the need to do so before your next session.

Confidentiality**:**
The law protects the privacy of all communications between a client and a psychotherapist. In most situations, I can only release information about your treatment to others if you sign a release of information form. However, there are some situations where I am permitted or required to disclose information without either your consent or Authorization. They are as follows:

- As mentioned above, Hemenway Family Therapy and Wellness, LLC works on a collaborative basis. We consult with each other and at times with outside professionals. The other professional(s) are also legally bound to keep the information confidential.
- If you threaten bodily harm or death to another person, I am required by law to inform the intended victim and appropriate law enforcement agencies.
- If you threaten bodily harm or death to yourself, I may need to inform the law enforcement agencies and others (spouse, friend, psychiatric care facility) who could aid in prohibiting you from carrying out your threats.
- If you reveal information relative to child abuse/neglect or dependent adult abuse/neglect, I am required by law to report this to the appropriate authority.
- If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient to defend myself.
- If you are in therapy by order of a court of law, the result of the treatment ordered may be revealed to the court.

Client/Guardian Initials: ____________

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- If a court of law issues a legitimate subpoena, I may be required to provide the information requested in the subpoena. In the case of a court subpoena I will object to the release of client files to the best of my ability but this can be overridden by a judge's order.
- Any circumstance in which I am mandated to report by law.

Age Exception:
If you are under (18) eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment as well as any potential safety concerns.

Financial Practices:
All fees are payable at the time of service
Fees for Services: Therapy sessions are forty-five (45) to fifty-five (55) minutes in duration.

Session Fees:
Initial Intake Assessment: $150.00
Individual Psychotherapy: $130.00
Couple/Family Therapy: $150.00

Adjusted Fees and Payment Schedules: Adjusted fees and payment schedules must be arranged prior to scheduled treatment; they will be based on need, and held confidential.

Adjusted Fee Agreement:
Initial Intake Assessment: ________
Individual Psychotherapy: ________
Couple/Family Therapy: ________

Payments for Services: Fees/co-payments are to be paid at the time of the session. Payments can be made via cash, check, or through the IvyPay app. Please make checks payable to "Hemenway Family Therapy and Wellness, LLC." There will be a $10.00 charge for all returned checks. Regardless of medical coverage, you are responsible for your fees for professional services. Clients who default on their financial obligations will be referred to a contracted collection agency and revoke the right to confidentiality in this process. Defaulting clients will be liable for all collection costs including agency fees and legal fees.

Cancelled or Missed Appointments: If you are unable to attend your scheduled appointment, a minimum of twenty-four (24) hours' notice must be given to avoid a missed appointment fee. If less than 24 hours are given before cancellation or an appointment is missed without cancellation (no-show), you will be charged a $75.00 missed appointment fee. Insurance will not cover any of this cost and you are responsible for the full fee. Appointment rescheduling will be at the discretion of the clinician.

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Insurance Coverage: Insurance claims will be submitted for the cost of services, which may include outpatient treatment reports and diagnostic treatment summaries. All insurance claims are submitted and processed through a contracted billing agency called Therapist Solutions. You are responsible for informing your clinician of any changes in your insurance information, including coverage changes. If you fail to inform your clinician of any changes, you may become responsible for payment in full for professional services. You are responsible for the costs of professional services, regardless of coverage. If insurance benefits are utilized, you are responsible for all co-pays or deductibles at the time services are rendered.

By signing this form, you are authorizing Therapist Solutions to process insurance claims, and authorizing insurance carriers to make payments directly to your provider. If your insurance carrier will only submit payment directly to the client, you are responsible for paying for services in full at the time rendered, and then seeking reimbursement from said insurance carrier.

Records:
I am required to maintain complete treatment records. Clients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the client's appropriate designee. Clients will be charged an appropriate fee for preparation. Please be aware that I use a confidential and secure electronic health record (EHR) to store client information and billing information.
If you would like me to complete any paperwork on your behalf please give me at least two weeks' notice in order to guarantee timely completion of the documentation. Please be aware that I do not provide recommendations on child custody issues or participate in any court proceedings. My reports simply provide documentation of dates of service, diagnoses, my observations, client and family report, and treatment progress.

Limitation of the therapy contract:
Your therapist is not a physician and cannot prescribe medication or give recommendations about physical problems. Nevertheless, depending on the nature of the presenting problems, your therapist might require you to consult with a physician before proceeding with therapy. Your therapist cannot guarantee that each person's goals in therapy will be met completely. Seeking to resolve issues between family members and other persons can lead to discomfort, as well as relationship changes that may not be originally intended.

Potential Risks of Treatment:
Throughout the course of treatment there is the possibility for individuals to experience uncomfortable feelings such as anger, sadness, anxiety or unpleasant memories. Though these can be difficult things to experience they are often a necessary and vital part of the therapeutic process. Please understand that this is a safe place in which to "go there" and speak about potentially uncomfortable topics. Therapy will be the most effective and beneficial for clients who value their and my time by being consistent and timely in treatment participation. The client who is engaged in session, open to new ideas and different perspectives and is motivated for change, is the client who will gain the most from this experience.

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Consent to Treatment:

I, ____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned below, at the office of Hemenway Family Therapy and Wellness, LLC. The rights, risks and benefits associated with the treatment have been explained to me.

Client Name: ___________________________________

Client/Guardian signature: _____________________________________

Today's Date: _________________________