Therapeutic Freedom
9701 Apollo Drive
Largo, MD 20774

INFORMED CONSENT FOR PSYCHOTHERAPY AND COUNSELING

MY RESPONSIBILITIES TO YOU AS YOUR THERAPIST

I. CONFIDENTIALITY

Apart from certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. Under the provisions of the Health Care Information Act of 1992, I may legally speak to certain individuals including but not limited to: health care providers, health care agencies or members of your family about you without your prior consent in the event of an emergency. A list of legal provisions to the confidentiality and privacy rule are listed on the HIPPA Notice of Privacy Notice. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA).

It is my duty to protect you, your child(ren) and/or families privacy even if you do release me in writing to share information about you, your child and/or family. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

If you elect to communicate with me by email at some point in our work together, I am willing to respond briefly by return email but will not include any confidential information about therapy sessions, treatment plans and/or personal/medical information. I can send email reminders for appointments and share general information electronically.

The following are legal exceptions to your right to confidentiality. While I have a duty to warn, I would inform you of any time when I think I will have to put these into effect.

1. If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
2. If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.
3. If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would take the best steps to ensure your safety.

II. RECORD-KEEPING

I keep brief records of each session noting the dates we meet, the topics we cover, progress reports from the client's perspective, interventions and impressions from the therapist and next

steps. My records are kept private and not shared with others, in accordance with HIPPA requirements.

III. DIAGNOSIS

If a third party, such as an insurance company, is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you.

IV. OTHER RIGHTS

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time, although I recommend finding a way to give me advance notice so that I can help you end treatment well and consolidate gains.

V. FEES/CANCELLATIONS

I provide 15 minutes of free initial consultation to determine the need for services via phone. The fee schedule is noted below:

- $45/session

You will be asked to pay for each session at the time of the session. Payment can be by cash or credit card. You can also be invoiced for your session a week prior to the date of your appointment. **All fees would need to be paid by the date of your appointment.** A receipt will be sent electronically at the end of each week noting the paid sessions. You can use the statement for reimbursement from your insurance, if applicable. If you prefer to receive the statement in another way, let us know. As of now, clients work via a private contract and informed consent with Therapeutic Freedom and are liable for charges of his/her services.

I completely understand that emergencies arise and I will try to be as accommodating as I can to your schedule. **If you need to cancel/reschedule sessions, I will need 24 hours notice. You will be billed fully for missed/no-show appointments at the rate listed above.** If I need to cancel an appointment, you will not be charged for the session and I will try my best to reschedule your appointment within the week.

Each client's session is reserved specifically for them. For this reason, visits will begin and end on time, and I am unable to extend a session beyond the agreed upon time. Thus, if a client arrives late for his/her scheduled appointment, that time is lost from the session. If I am late, I will make sure that you get your full appointment time.

Consent to Treatment (to be completed by CLIENT or PARENT/GUARDIAN, if client is under 18):

I, _____, voluntarily agree to receive mental health assessment, care, treatment, or services, and authorize Therapeutic Freedom, to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will

participate in the planning of my or my child's care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. By signing this consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein.

PARENT/GUARDIAN Printed Name (if Client under 18): _____

CLIENT (Person being seen) Printed Name: _____

CLIENT Signature (or Parent/Guardian, if Client under 18): _____

DATE: _____