Desert Hope Psychotherapy and Consultation Services, LLC

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Informed Consent for Assessment and Treatment

Welcome to Desert Hope Psychotherapy and Consultation Services. This document contains important information about my professional services and business policies. Please read it carefully and feel free to ask questions. When you sign this Informed Consent Document, it will represent an agreement between us.

Education: My credentials include a Master of Arts degree in Counseling and Guidance specializing in Family and Agency Counseling. I am dual licensed by the Arizona Board of Behavioral Health Examiners as a Licensed Marriage and Family Therapist (LMFT) and as a Licensed Professional Counselor (LPC).

Services Provided:

1. Purpose of Treatment: The purpose of counseling or psychotherapy involves change. Change encompasses helping you and or other family members to deal with stresses and concerns in your lives, to achieve your personal goals, and to improve your relationships with significant others. Counseling can give you the tools to develop your own solutions as well as learn how to deal with the difficulties in your life. Psychotherapy calls for a very active effort on your part. For therapy to be successful, you will have to work on the things we talk about both during our sessions and at home. Your treatment with me is optional and you are free to limit or end treatment at any time.

As your therapist, I am responsible to provide you with the highest level of professional skills commensurate with my training and experience.

2. Process -Types of Therapeutic Approaches: In helping you to make changes, I will focus with you on your cognition or thinking, your emotions, your behavior and your relationships with others. I may utilize a variety of therapy modalities that may involve Individual therapy, Marriage and Family therapy, Relationships, Group therapy, and Education. We will negotiate “homework” or activities you will practice outside of our scheduled sessions together. We will focus on your strengths as a way for you to make changes in your life.

At the beginning of our work together and at periodic times throughout the therapy process, I will utilize standardized assessment instruments. These assessment instruments will be come part of your Client Record. These assessment instruments will help us both to better understand your strengths. The assessment instruments will include a Psychosocial Assessment, Mental Status Examination and initial diagnosis. Subsequent assessment instruments may be utilized as needed.

Our first few sessions will involve evaluating your needs and clarifying the goals of your treatment. Crucial to your treatment will be the development of a written treatment plan that will outline our agreed upon goals for treatment, and the methods of treatment. We will review the treatment plan as needed (minimally once per year per Arizona Statues) to ensure we are meeting your treatment needs. The Treatment Plan will be revised as needed to reflect changes in our goals and treatment methods.

At times during treatment, adjunctive therapy may be required. I will recommend, if necessary, that you consult with a physician for medical evaluation and treatment. This may include referrals to a psychiatrist or your primary care physician for medication therapy. I may suggest that you get involved in a therapy or support group as part of your therapy with me. If another health care provider is working with you, I will need a Release of Information form from you so that I can communicate with that person about your care. You have the right to refuse any recommendations that I suggest.

Risks of Treatment

Psychotherapy can have benefits and risks. Therapy can involve discussing unpleasant aspects of your life; you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. Therapy can make changes in your life that can lead to a better sense of self, solutions to specific problems, significant reductions in feelings of distress and better relationships. If I propose a specific technique that may have special risks attached, I will inform you of that and discuss with you the risks and benefits of my suggestions. You have the right to refuse any recommendations that I suggest. There are, however, no guarantees of what you will experience.

You normally will decide when therapy will end; however there are three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you do violence to, threaten, verbally or physically, or harass myself, the office or my family, I reserve the right to terminate you unilaterally and immediately from treatment. I will offer you referrals to other treatment providers if I terminate you from therapy.

Contacting Me

I am often not immediately available by telephone as I may be with another client. When I am unavailable, my telephone is answered by voice mail that I frequently monitor. I will make every effort to return your call on the same day you make it, except for weekends and holidays. If you are difficult to reach, please inform me of times and/or ways that I can contact you. In the event of a life-threatening emergency, immediately call 911 or go to the nearest hospital emergency room. Your safety is my primary concern and I will contact you as soon as possible.

Confidentiality

In general, the privacy of our therapy sessions and communications is protected by law; I can only release information about you to others with your written permission. I am committed to the confidentiality of all personal information shared in our therapy sessions, except in circumstances governed by law.

The rules and laws concerning confidentiality, privacy and records are complex. The HIPAA NOTICE OF PRIVACY PRACTICES, included with this document, details the considerations regarding confidentiality, privacy and your records. This document contains information about

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your right to access your records and details the procedures to obtain them, should you choose to do so. Periodically, the HIPAA NOTICE OF PRIVACY PRACTICES MAY BE REVISED. Any changes to these privacy practices will be posted in my office, and you will receive an individual notification of the updates. **It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment**.

State and Federal laws limit confidentiality, in general to situations in which there is a real or potential danger to you or others, when the courts issue a subpoena, or when child/elder abuse or neglect is involved. There are also numerous other circumstances when information may be released including but not limited to when disclosure is required by the Arizona Board of Behavioral Health Examiners, when a lawsuit is filed against me, to comply with worker compensation laws, to comply with the USA Patriot Act and to comply with other federal, state or local laws. Please see the HIPAA NOTICE OF PRIVACY PRACTICES for a more extensive listing of limits to confidentiality.

Unless otherwise required by statute or by federal law, I will retain your clinical record for at least six years after your last clinical appointment. Children and adolescent clinical records will be retained for three years after the child's eighteenth birthday or six years after the last clinical appointment, whichever comes first. In the event I terminate my clinical practice, I will make a good faith effort to contact you, based on your last known address, and make your clinical record available to you. Any clinical records that have not been distributed, per the client's request, will be destroyed after seven years. Records will be destroyed by an approved agency responsible for record destruction.

_____ Initials	**I have read the HIPPA NOTICE OF PRIVACY PRACTICES, and have had my questions about privacy and confidentiality answered to my satisfaction. I understand that the HIPPA NOTICE OF PRIVACY PRACTICES is incorporated by reference into this agreement.**

HIPPA Privacy and Security rules not only allow but require me to communicate with you by e-mail or text if requested and initiated by you. I am responsible for implementing appropriate safeguards when e-mailing or texting e-PHI (electronic Protected Health Information). E-mails and texts pose a security risk. It is my policy not to initiate any communication by e-mail, texting, or social media. I will not transmit any PHI. I will contact you by phone or letter and after confirming your identity, discuss any PHI needs.

Please be aware that I utilize computer software for billing information. I will use reasonable back up, security and other safeguards to protect your information.

I also participate in case consultation where selected cases are discussed with other professional colleagues to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. While no identifying information is released, the dynamics of the problems and the people are discussed along with treatment approaches and methods.

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Occasionally, when I am unavailable or out of town for an extended period, I may have another licensed therapist cover for me. I reserve the right to disclose confidential information from your records to this covering therapist in order to facilitate coverage of your care in my absence.

A minor child's clinical record and information is available to the child's legal representative or parent in accordance with A.R.S 12-2293.

In the event of my death, retirement, or incapacity, the clinical records for my clients that are actively receiving services will be referred to one or more local behavioral health professionals to facilitate the continuation of treatment. In such a situation, you have the right to continue treatment with this professional, discontinue treatment or ask for a referral. Records for my inactive clients will be handled by a "records custodian" who may be an individual or company. The custodian will be responsible for satisfying records requests and destroying records when the legal time frames for records retention are satisfied.

***Telebehavioral* Health and Telepractice**

I offer tele-behavioral or tele-practice as a therapeutic modality in my practice. This modality is offered to my clients who are unable to participate in an office setting for therapy. This may occur due to illness and medical concerns or distance. This modality of treatment involves this written consent and verbal consent as well. The verbal consent is documented within the progress note; the consent can be withdrawn at any time. If you elect to participate in the tele-practice, you will need to document your identity and location.

There are a number of risks to tele-behavioral or tele-practice as a modality of practice. There are inherent confidentiality risks with electronic communication. I will utilize a HIPPA compliant tele-practice software to insure confidentiality. In addition, this modality has a potential for technology failure. In the event of technology failure or emergency procedures to contact me will be reviewed at the beginning of each session.

Methods for Obtaining Information from Record-Record keeping

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are clinical records, they can be misinterpreted by untrained readers. If you wish to see your records, we can review them together and discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Requests from the client, authorized guardian or Releases of Information will be responded to within 14 days

Meeting Times

Regular attendance at your scheduled appointments is important for a successful outcome in therapy. I schedule the initial assessment for 1 and a half hours. Subsequent appointments are usually scheduled for one 50-minute sessions (one appointment hour of 50-minute duration) per the frequency schedule we agree upon although some sessions may be longer. Family sessions are scheduled for 1 and a half hours.

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Appointments canceled at the last minute are detrimental to my practice. Once an appointment is scheduled, you will be expected to pay for the session unless you notify me a minimum of one full business day (24 hours, Monday through Friday) prior to your appointment if you need to cancel. **Repeated late cancellations or missed appointments will be billed at the full fee and may result in termination of treatment. In addition, if you arrive more than 15 minutes late to an appointment, I cannot bill the insurance company for a full session, and you will be expected to make up the difference. Please note that these are personal financial obligations that <u>you</u> are responsible for, and not the obligations of your insurance company.**

Appointment variability varies with the client load at the time. I reserve the right to limit my commitments of high demand appointment times to any client in order to meet the needs of all my clients and to balance my workload.

<u>Professional Fees</u>

My initial evaluation fee is $196.00. Subsequent hourly appointments are $140.00. Family therapy with 3 or more persons is $175.00 per session. Group therapy sessions are billed at $50.00 per session. I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. I charge $120.00 per hour for preparation and attendance at any legal proceeding. The basic fees are posted in m office, and fee information for those not listed is available upon request. I reserve the right to change my fees with a 30 days notice.

<u>Billing and Payments</u>

Payment is expected at the time the service is rendered unless other arrangements have been made. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

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 legal action is necessary, its costs will be included in the claim. In collection situations, the only information I release is the client's name, the nature of the services provided and the amount due.

<u>Insurance</u>: I am a preferred provider for several health plans. If you are using one of these plans to pay for your treatment, the terms that govern the plan will apply (i.e. co-payments, deductibles, insurance filing, etc.) If you are using another insurance program, I will supply you with a super bill that you can turn into your insurance company so they can reimburse you. In all cases, however, payment for services is ultimately the responsibility of the client, not the insurance company. Once again, please discuss this with me if you want to use this payment option.

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Your insurance company or managed care company may limit the number of sessions based on their assessment of medical necessity or other factors. Their determination may or may not match what you want or need in treatment. In the even that they will not authorize additional sessions or you exhaust the sessions that your insurance will provide, you understand that you will have to pay for the additional services rendered. In addition, if your insurance company or managed care company denies payment for any service defined as non-covered, you will be responsible for the amount due. Using a third party to pay for therapy implies that some information will be released to obtain payment for the services.

Your Responsibilities

Your therapy will begin with one or more sessions devoted to an initial assessment so that I can understand the issues, your background, and other factors that may be relevant. When the initial assessment phase is complete, we will discuss ways to treat the problem(s) that brought you into therapy and to develop a plan of treatment. You have the right and obligation to participate in treatment decisions and in the development and periodic review and revisions of your treatment plan. You also have the right to refuse any recommended treatment or to withdraw consent and to be advised of the consequences of such refusal or withdrawal.

Our Relationship:

The client/counselor relationship is unique in that it is exclusively therapeutic. It is inappropriate for a client and therapist to spend time together socially, to bestow gifts or to attend family or religious functions. The purpose of these boundaries is to ensure that you and I are clear in our roles for you treatment and that your confidentiality is maintained.

If there is ever a time you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of therapy as soon as possible. This includes administrative or financial issues as well.

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<u>Consent for Evaluation and Treatment</u>: Consent is hereby given for evaluation and treatment under the terms described in this consent document. It is agreed that either of us may discontinue the evaluation and treatment at any time and that you are free to accept or reject the treatment provided. In the case of a minor child, I hereby affirm that I am the custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signature:_____ Date:_____

In the case of a minor child, please specify the following:

Full name of Minor:_____ DOB:_____ Relationship:_____

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For Office Use Only-Verification that client has read and understands the Informed Consent Document.

Authorized Representative:_____Date:_____

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