

Lawrence Family Therapy- Consent to Treatment

Client Name: _____

Date: _____

For us to consider providing services to you or your child, you must *read and sign* this consent form. This is *not* a contract. It just allows us to see you. You may withdraw this consent to treatment at any time and ask that your file be closed. You should also know that this is not an agreement by Lawrence Family Therapy to provide services to you. You may wish to talk with your therapist about your consent to treatment during intake session. She will answer your questions.

Understanding Psychotherapy and/or Other Services LFT Provides. Psychotherapy services and other services LFT provides are designed to help you change. Sometimes this kind of change is difficult because it raises feelings, thoughts, and worries that you try to keep inside. The benefits may include improved behavior, relationships, and mood. You may learn to communicate better with those around you. You should know that this is not a precise science. In many cases we are successful in helping people to change. In some cases we are not. Lawrence Family Therapy cannot guarantee the success of any treatment.

Lawrence Family Therapy is owned and operated by Alicia Lawrence. Mrs. Lawrence is a Licensed Specialist Clinical Social Worker. You may also receive services from a contracted employee of Lawrence Family Therapy. Contracted employees are required to a licensed professional through the KS BSRB.

Grievance Procedure. At times clients in psychotherapy may find themselves in conflict with their therapist about some aspect of treatment. This may come from a misunderstanding between client and therapist, or a genuine disagreement in how treatment should proceed. We attempt to resolve any conflicts in a manner that is suitable to our clients, while maintaining important treatment standards. If you reach a point of conflict in your treatment, you should first attempt resolution with your therapist. If this does not solve the conflict, we may suggest seeking services elsewhere. You may also contact your insurance provider.

Second Opinions and Service Referral. Clients are entitled to a second opinion. A second opinion may be helpful when you do not agree with a Lawrence Family Therapy diagnosis or treatment finding. Lawrence Family Therapy does not usually make specific recommendations about where or when to seek a second opinion. At times however, Lawrence Family Therapy may find that we do not have adequate training, experience, or services to properly address your needs. In this case we may recommend other resources that are more suitable. This is especially true for adults, who may require services that we do not offer or that we cannot easily access. Client's may contact MCO for referrals.

Confidentiality. All services provided are *strictly confidential*. We cannot release any information about your case to anyone outside Lawrence Family Therapy without your written consent. **Breaking Confidentiality.** *There are exceptions to confidentiality. Below are reasons this may occur:* (1) **Duty to Warn and Protect.** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. (2) **Abuse of Children and Vulnerable Adults.** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. (3) **Prenatal Exposure to Controlled Substances.** Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. (4) **Minors/Guardianship.** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. (5) **Insurance Providers AND Billing Providers:** Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. (6) **Court of law subpoenas (demands to see) the records.** If this happens, we will attempt to invoke *privileged communication* (a legal protection of your right to therapeutic confidentiality) if you or your attorney asks us to do so. However, under some circumstances, the court can override privileged communication and order us to disclose these records.

Lawrence Family Therapy reserves the right to contact the police anytime danger of self or others is of concern.

Email Contact. At your discretion you may contact your therapist via email for the same purpose you would initiate phone contact. However, for therapy you are advised against using unsolicited fax transmissions as they are not monitored as closely. Lawrence Family Therapy does not consider email contact to be therapy and does not bill it as such. It is instead considered administrative and supportive contact. By initiating email contact you are accepting this understanding and agreeing to act accordingly. You are advised that email communication is protected by federal law, but should not be considered secure. It is possible that someone on the Internet might read your communication or our communication back to you. By initiating this sort of contact you are waiving this level of confidentiality unless you specify in your email a limitation of the expected response (e.g., "please don't reply"). If you are especially concerned about this issue, please discuss it with your therapist at intake. **Text Messaging.** Some therapists have found that text messaging can be a very helpful tool in keeping in touch. Please provide your text information OR advise your therapist if you DO NOT want to be contacted by text messaging.

Crisis Intervention. As a family therapy practice, Lawrence Family Therapy specializes in working with children, teenagers, families, adults, and couples. If you expect to need crisis intervention – or have used psychiatric crisis intervention in previous therapies – you need to be aware that Lawrence Family Therapy is limited to meet your needs. Please talk with your therapist about what is available for adult crisis management and community alternatives. After-hour emergency should be report to your local Mental Health Center, hospital, and/or call 911.

Working with your Physician. It is often in your clinical best interest for Lawrence Family Therapy to work with your physician. This is especially true when you are being seen here for medication. By signing this document you are agreeing to have us contact your physician as necessary to coordinate treatment. If you do not wish to have us contact your physician please mark this box:

____ (initial) I am withholding information for Lawrence Family Therapy to contact my physician regarding my case.

Obligation. By signing this document, you are agreeing to pay for the services you receive at Lawrence Family Therapy. Please read each of the follow paragraphs to assure your understanding of our billing procedure and ask your therapist if you have any questions about these procedures.

EVERYONE MUST READ AND CHECK ONE OF THE FOLLOWING BILLING OPTIONS:

Self-Pay: I do not have or do not wish to use my insurance. I am paying all fees in full by cash or check. The agreed hourly amount is \$ _____.

Kancare _____: I have KANCARE. I will notify my therapist if my KANCARE card is no longer active.

Other: _____

I understand that all missed appointments and late cancellations incur a charge 100% your agreed session amount. A missed appointment is any appointment not cancelled. A late cancel is any appointment not cancelled with 24 hours notice. Fees for missed or late-cancelled appointments due to legitimate emergencies may be waived. Lawrence Family Therapy may offer reminders to clients, but failure to send a reminder does not release me from paying a no-show fee. No showing or late canceling two appointments may result in losing regular therapy appointment time and/or may be put on a call list. Termination of services may occur if 3 or more missed appointments occur.

I understand that I must pay all costs not paid by my insurance carrier. If I am over the age of 18, and have a parent or other party (guarantor) paying my bill, I understand that I remain *primarily responsible*. This means that if that person does not pay outstanding charges, I remain liable for them. I also understand that I am subject to collection action if my account becomes past due and I have not placed a credit card or checking account number on file to make regular payments. By signing this document I am releasing Lawrence Family Therapy to provide necessary information to its designated collection agency. I also understand that if I move or relocate without making arrangements with Lawrence Family Therapy for future billing, I am subject to immediate collection action. I also understand that if my check is returned, fees up to 25% of the face value of the check will be added to any delinquent account placed for collection.

I have read the above statement or had it explained to me and my questions have been answered. I consent to receive services from Lawrence Family Therapy if they are offered under these terms. I realize that these are the core issues of informed consent and that others may come up during my therapy. If that happens, I am free to talk to my therapist about these issues.

Client or (parent or guardian to child under 18)

Today's Date

Print Name

**Notice of Lawrence Family Therapy
Policies and Practices to Protect the Privacy of Your Health Information**

I and/or my legal guardian have been offered an office copy of the Lawrence Family Therapy HIPPA Policy.

Client signature

Date

Parent or legal guardian signature (if under 18)

Date

Relationship to client

Lawrence Family Therapy, LLC
 Release of Information from Lawrence Family Therapy, LLC to Another Agency

Client Name:	Date of Birth:
Guardian (if under 18):	Relationship to client:

By signing this form the above noted client (or guardian) indicates understanding of the following:

- The client (or guardian) is voluntarily waiving a specific right of confidentiality allowing Lawrence Family Therapy to release information to the following agency(s).
- The purpose of this release is to facilitate a comprehensive treatment plan or provided feedback to other parties with a bona fide interest in this case. Lawrence Family Therapy will only release information about a client or former client which is judged by its staff as necessary for evaluation and/or treatment coordination and planning. Specific limitations to this release are noted here:
- Lawrence Family Therapy is not obligated to open its records to another agency, nor to provide any information beyond the scope of this release.
- This release is given voluntarily in accordance with Kansas Statute KSA 59-2931, and KSA 1987 Supp 65-5601 to 65-5605 and all amendments thereto, as well as applicable federal guidelines for the keeping of medical and psychiatric records. Pursuant to those statutes Lawrence Family Therapy may refuse to disclose portions of these records if it is determined in writing that such disclosure will cause harm to or threaten the welfare of the client. Due to Federal law (42 CFR Part 2), no agency or organization may re- release records provided by another, though Lawrence Family Therapy cannot guarantee that the recipient of these records will abide by these regulations.
- This release may be revoked (taken back) at any time, though this will not affect records or information already released. The client (or guardian) must provide a written request to terminate the release. Otherwise, this release will expire 60 days after termination of treatment and must be renewed by the client (or guardian) if records are to be released after that time.

By signing this form the above noted client (or guardian) requests release of information to the following:

<input type="checkbox"/> Attorney: Name: <input type="checkbox"/> Bert Nash Community Mental Health Center <input type="checkbox"/> Community Corrections <input type="checkbox"/> DG <input type="checkbox"/> FR <input type="checkbox"/> JO <input type="checkbox"/> JF <input type="checkbox"/> JA <input type="checkbox"/> WY <input type="checkbox"/> Court Appointed Special Advocate (CASA) <input type="checkbox"/> District Court (including DA and Judge) County: <input type="checkbox"/> DG <input type="checkbox"/> FR <input type="checkbox"/> JO <input type="checkbox"/> JF <input type="checkbox"/> JA <input type="checkbox"/> WY <input type="checkbox"/> DG County Rape Victim/Survivor Services <input type="checkbox"/> DCCCA	<input type="checkbox"/> DCCCA Substance Abuse Services <input type="checkbox"/> Juvenile Justice Authority <input type="checkbox"/> KVC Behavioral Health <input type="checkbox"/> Kansas Children s Service League <input type="checkbox"/> Lawrence Memorial Hospital <input type="checkbox"/> Lutheran Social Services <input type="checkbox"/> Mental Health Center: Name: <input type="checkbox"/> Menninger Clinic <input type="checkbox"/> Physician: Name: <input type="checkbox"/> School Districts, USD:	<input type="checkbox"/> Soc Security Administration <input type="checkbox"/> Services for Alcohol Related Problems (SARP) <input type="checkbox"/> The Shelter <input type="checkbox"/> Dep Child/Fam Area Office (other): <input type="checkbox"/> DG <input type="checkbox"/> FR <input type="checkbox"/> JO <input type="checkbox"/> JF <input type="checkbox"/> JA <input type="checkbox"/> WY <input type="checkbox"/> Therapist: Name: <input type="checkbox"/> The Farm <input type="checkbox"/> Women's Transitional Care Services <input type="checkbox"/> Women's Recovery Center <input type="checkbox"/> Other Describe:
--	--	--

By signing this form, I indicate that I understand and agree with the terms, nature, extent, and purpose of this release, and acknowledge that all my questions about the release have been asked and answered.

Signature of client or guardian _____

Date _____

Print Name _____