JALU Creative Healing, LLC

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Informed Consent for Assessment & Treatment

The purpose of this information is to help you to make an informed decision about participating in treatment. Please read it carefully and discuss with me any questions that you may have. A copy of this consent form is available by request.

About the Therapy Process

Most people attend therapy with the goal to find relief of emotional and relational concerns. My approach is to help you increase your emotional awareness, develop skills and work through events that bring you distress, through action oriented, and strengths based interventions. It is important for you to know that therapy has both benefits and risks. Therapy often requires recalling unpleasant events and struggling with troubling issues. Consequently, people sometimes experience uncomfortable feelings such as sadness, fear or loneliness. However, therapy has been shown to have benefits for those who undertake it. While I will assist you in creating change in your life, I cannot guarantee a specific outcome. Although there are no guarantees about the outcomes of therapy, people often report significant reductions in feelings of distress, satisfactory resolution of specific problems and an improvement in relationships and overall quality of life.

The benefits of online therapy include immediate access to services, convenient scheduling, privacy, and reduced or eliminated transportation barriers. Examples of potential risks in online therapy are the lack of visual and auditory cues, delayed responses, the need for crisis services, confidentiality breaches, and technological failures.

THE CLIENT'S ROLE IN THE COUNSELING PROCESS

There are several things I ask of my clients as we enter in to a therapeutic counseling relationship:

- I believe that you are the expert on yourself. I will use my best professional self to lead our sessions, but I ask that you are open and honest with me about how you are experiencing our counseling relationship. I am trusting that you will be honest about what you find helpful, confusing, frustrating, beneficial, etc. during the counseling process.
- I am committed to helping you along your healing journey, and I ask that you be committed as well. During our first session we will discuss frequency of sessions. Please be committed to attending our sessions.
- Please be committed to any "homework" I assign you outside of sessions. I find that the more committed a client is outside of our sessions, the faster progress can be made and goals reached.
- I find that when the counseling process is finished, the closure portion can be one of the richest and most important aspects to both client and therapist. No matter the circumstance around you ending counseling with me, please be respectful to the idea of closure and allow us at least one session to process the ending of our time together.

About Me

I am a Licensed Clinical Social Worker with a Masters Degree in Social Work from Florida Atlantic University. I am licensed with DORA in the state of Colorado and my license number is CSW-09926554.

Your Rights as a Client & Disclosure Statements

1. You have the right to ask questions about and/or refuse any therapeutic technique or recommended treatment and the right to be advised of the consequences of such refusal or withdrawal.

2. You have the right to end therapy at any time without any moral, legal or financial obligations other than those already accrued. If you wish, I will provide you with the names of other qualified therapists.

3. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan.

4. You have the right to request your medical and billing records. Please see HIPPA form for procedure.

5. If my primary therapist believes my therapeutic issues are above her or his level of competence, or outside of his or her scope of practice, he or she is legally required to refer, terminate, or consult.

6. I understand that I am legally responsible for payment for my therapy services. If for any reason, a third-party payor does not compensate my primary therapist, I understand that I remain solely responsible for payment. I also understand that signing this form gives permission to my primary therapist to communicate with anyone connected to my therapy funding source regarding payment. I understand that certain third-party payors may request information from my primary therapist about the therapy services I received which may include but is not limited to: a diagnosis or service code, description of services or symptoms, treatment plans/summary, and in some cases my entire client file. I understand that once a third-party receives the information, I or my primary therapist has no control of the security measures the third-party takes or whether the third-party shares the required information. I understand that I may request from my primary therapist a copy of any report he/she submits to any third-party on my behalf. Failure to pay will be a cause for termination of therapy services.

7. I understand that this form is compliant with HIPAA regulations and no medical or therapeutic information or other information related to my privacy, will be released without permission unless mandated by Colorado law as described in this form and the Notice of Privacy Policies and Practices. Consistent with HIPAA guidelines authorization for release and consent for treatment will be automatically revoked two years after the signing date, unless otherwise allowed by law.

8. I understand that if I have any questions about my primary therapist's methods, techniques, or duration of therapy, fee structure, or would like additional information, I may ask at any time during the therapy process. I understand that to include my partner, spouse, significant other,

parent(s)/legal guardian(s), or other family members in my therapy, I will have to sign a separate Release of Information.

9. Because of the nature of therapy, I understand that my therapeutic relationship has to be different from most other relationships. In order to protect the integrity of the counseling process the therapeutic relationship must remain solely that of psychotherapist and client. This means that my primary therapist cannot be my friend. My primary therapist cannot have any type of business relationship with me other than the counseling relationship (i.e. cannot hire me, lend to or borrow from me; or trade or barter for services in exchange for counseling). My primary therapist cannot have any kind of romantic or sexual relationship with a former or current client, or any other people close to a client. My primary therapist cannot hold the role of counselor to her/his relatives, friends, the relatives or friends, people s/he knows socially, or business contacts. In a professional relationship, sexual intimacy between a psychotherapist and a client is never appropriate. If sexual intimacy occurs it should be reported to DORA at (303) 894-2291, Mental Health Section, 1560 Broadway, Suite 1350, Denver, Colorado 80202; State Board of Social Work Examiners or the State Board of Registered Psychotherapists.

10. I also affirm, by signing this form, I am at least fifteen (15) years old and consent to treatment and therapy services or that I am the legal guardian and/or custodial parent with the legal right to consent to treatment for any minor child/ren who is under the age of fifteen (15).

11. I understand that if I am consenting to treatment for my minor child/ren that my primary therapist will request that I produce the Court Order Custody Agreement and/or Parenting Plan that grants me such authority. Further, I understand and agree to keep my primary therapist informed of any proceedings or supplemental court orders that affect my parenting rights, custody arrangements, and decision-making authority; I understand that failing to do so will prohibit my primary therapist from providing therapy to my minor child/ren. I understand that it is beyond the scope of my primary therapist's practice to provide custody recommendations; a Court is able to appoint professionals with the expertise to make such recommendations.

12. By signing this form, I affirm that I am fully informed of the therapy services I am requesting at JALU Creative Healing LCC, and grant my consent to receive such therapy services.

Therapy Services and Fees:

1. **Session Fee:** A therapy hour is 50 minutes. My standard fee is $150 per 50-minute session, $300 per 100- minute session (a "double" session) and $175 for family sessions. You are encouraged to schedule sessions as you feel will be helpful. I will recommend a schedule that I believe will be most beneficial for your goals.
2. **Payment:** Payment is due at the beginning of the session.
3. **No-show/Late Cancel:** If you are unable to attend your scheduled appointment, you must call 24 hours in advance or you will be charged a $50 late cancellation fee. If you do not show up to the appointment and do not give a late cancellation notice you will be charged the full session fee. Additionally, if your personal check is returned you will be charged a $25 fee.
4. **Other Fees:**

- Client phone calls: Calls are charged $25 for every 15 minutes. If call is under 10 min the fee
- Legal: Any work related to a legal situation (i.e. attorney calls, writing reports & court appearances) will be billed at $250.00/hr (billed in 15 minute increments). This includes preparation as well as travel time if applicable.
- Refund: If a client is due a refund, this will be provided by check or credit within 5 business days of therapist becoming aware of refund amount due.

Therapist Availability & Emergency Procedures

1. This practice does NOT have the capacity to respond to counseling emergencies. Emergencies should be directed to 911 or to the local hotlines: Contact 24-hour crisis lines local to your area, if needed. If you have a Psychiatrist, you should also contact him/her in times of emergent need.
2. You may leave a confidential message at any time with my answering service at (561) 945-2723. I check messages frequently throughout the day and will return your call as soon as I am able. On holidays, I check my messages less frequently and may only respond to urgent calls. Non-urgent phone calls are generally returned within 24 hours. If I haven't returned your call within 24 hours, please call again.
3. Email and text communication is for non-emergencies only. It may be used for appointment changes, referrals and non-clinical questions. I check emails as often as possible, but if you are canceling an appointment with less than 24 hours notice, please call the number listed above. I have no way to guarantee the confidentiality of electronic communication so please use at your own discretion. All non-routine emails/texts will be printed out/transcribed and kept as part of your permanent record.

CONFIDENTIALITY: Contents of all therapy sessions are considered to be confidential. The protection of your Personal Health Information (PHI) is very important to me and is also protected by HIPAA. Both verbal information and written records cannot be shared with another party without the written consent of the client or the client's legal guardian. I will do everything within my power to uphold confidentiality. Your online intake assessment will be encrypted and stored securely during our initial telehealth meeting. Videoconferencing software used in session, **Doxy.me,** uses encrypted point-to-point connections and is HIPAA-compliant; case notes are kept securely. Electronic Records: I may keep and store records for each client electronically on my laptop. In order to maintain security and protect the record, JALU Creative Healing, LLC employs the use of firewalls, antivirus software, changing passwords regularly, and encryption methods to protect computers and/or mobile devices from unauthorized access. In the event of devices being lost, stolen, or damaged, JALU Creative Healing LLC can also remotely wipe out data. While I use only the most secure resources, our work together is subject to the security of these online platforms, which include payment, intake, and videoconferencing software.

In most cases communications between client and therapist will be held in strict confidence - unless you provide your therapist written permission to release information about your treatment.

1. *Mandated Reporters.* Therapists are legally mandated to report all known or suspected instances of child abuse, dependent adult abuse and elder abuse to the appropriate authorities. Therapists are also required to notify the police as well as intended victim if it is determined that a client presents a serious danger of physical violence to another person. A therapist may break confidentiality when she believes a client is likely to be dangerous to him or herself.
2. HIPAA NOTICE OF PRIVACY PRACTICES, is available on request. It details the considerations regarding confidentiality, privacy, and your records. As expressed above, all of your information is kept secure. This Notice contains information about your right to access your records and the details of the procedures to obtain them, should you choose to do so.
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 (when applicable).* 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, description of impairment, progress of therapy, case notes, and summaries.
6. in the investigation of a complaint or civil suit filed against your primary therapist.
7. if your primary therapist is ordered by a court of competent jurisdiction to disclose generalized information.

SOCIAL MEDIA

Friend/Contact Requests: I do not accept personal friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it. Following: My primary concern is your privacy. I publish a blog and use my professional Facebook page and professional Instagram account to share blog posts, inspiration, and other interesting information related to my practice. You are welcome to use your own discretion in choosing whether to follow me on these platforms but there is no expectation of this. Note that I will not follow you back. My reasoning is that I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour. Same goes for if there were to be any encounters outside of therapy, in day to day life. If we were to see each other outside of the office or session, I will not make an attempt to say hello or approach you, in compliance with confidentiality. If you choose to approach me, I will follow your recommendation for how you would describe the nature of our connection.

My signature below affirms that the preceding information has been provided to me in writing by my primary therapist. If I am unable to read or understand this document, or have no written language skills, an oral explanation will be provided. Furthermore, should such assistance be required, I permit a Multi-disciplinary Team Representative or my Legal Guardian, to sign on my behalf with such information having been verbally explained to me. I understand my rights as a client/patient and should I have any questions, I will ask my therapist.

_____ Date _____
Client Name/Signature

_____ Date _____
Parent/Guardian Signature

_____ Date _____
Therapist Signature