



Office Policies and Agreement for Services

Therapy Services:

I utilize a variety of evidenced based practice modalities that are goal-directed and problem-focused. Goal of therapy are typically established during the first one or two sessions and are used as a way of measuring your success in counseling. Your active participation is required for you to receive the most benefit from counseling. **Please let me know of any concern(s) you may have regarding your therapy, so that we can attempt to resolve them together.**

_____ (initials)

Confidentiality:

Information you share inside of sessions will remain confidential to best of my ability. However, Parents and/or Legal Guardians do have the right to be told of the general content of therapy sessions involving their minor child, but this information will only be provided as requested by the parent or established legal guardian. In the event that other care providers, family members, friends, or other identified individuals are desired to be a part of therapy, written permission will be obtained through the use of a signed **Release of Information**. Only the parent, legal guardian, or legal adult can provide this consent. **Exceptions to this policy are as follows:**

Authorization to Release Information is NOT required in the following circumstances.

1. The client is identified and established to be a potential harm to self or others.
2. Suspected Child Abuse and Neglect or Dependent Adult Abuse and Neglect.
3. For purposes of billing
4. A court-ordered subpoena is presented.

_____ (initials)

Appointments:

Please make every attempt possible to attend ALL scheduled appointments. In the event you are unable, please call, text, or e-mail your therapist as soon as possible, preferably 24 hours in advance. Initialing this section grants permission to the therapist to send advanced notice text reminders of your scheduled appointment. Providing your e-mail address also grants the therapist permission to communicate with you through e-mail.

_____ (initials)

Unless restricted by a third party payer, you may be billed \$25 for any missed appointment. If this occurs, payment is expected prior to your next scheduled appointment.

Use of AI Generated Software:

I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our psychotherapy sessions. I have chosen to use Mentalyc's note-taking system for psychotherapy as part of my effort to provide the best care to my clients. It provides me with an automatically generated transcript and summarization of our sessions. Mentalyc's system is HIPAA compliant and uses up-to-date encryption methods, firewalls, and backup systems to help keep your information private and secure. You are consenting for me to process our sessions using Mentalyc's system.

Emergency Access:

In the event of a mental health emergency, please contact the 911; Foundation 2: 319-362-2174 or the Iowa Helpline: 1-855-800-1239 or contact your nearest emergency room or trauma center.

_____ (initials)

Insurance Coverage and Fees:

1. Payment for services is your responsibility. It is also your responsibility to obtain prior authorization for treatment (if needed). In most cases, your primary medical insurance will cover most of the cost for therapy. However, annual deductible amounts, often need to be met first. You will be billed for co-payments or co-insurance amounts as per your policy. **Co-payments on the day of service is preferred, but if you are unable, then you will be billed.** Prompt payment is appreciated.

_____ (initials)



Consent for treatment:

I authorize and request my therapist carry out mental health treatment during the course of my counseling sessions. I understand that while the course of my counseling is designed to be helpful, my therapist makes no guarantees about the outcome of treatment. I understand that through the course of counseling, there are both benefits and risks. Potential benefits include, but are not limited to: improved relationships, conflict resolution, illness education and treatment, and improved skills in emotion management, etc. Potential risks include: emerging negative or disturbing feelings and emotions related to the topic(s) of discussion during counseling and possibly worsening symptoms prior to positive change taking place. These possibilities can typically be managed successfully through continued counseling, however. If you are a parent or legal guardian, you are accepting these policies on behalf of the person you are representing by show of your signature below.

_____ (initials)

I have read this policy statement and agree to the terms.

Client/Legal Guardian Signature

Date

Printed Name

Practitioner/Witness Signature

Date