SERENITY AND SAGE COUNSELING SERVICES, LLC

Informed Consent for Therapy Services
Therapist-Client Service Agreement

Vision Statement: Within the spirit of service, members of our community will be empowered to conquer challenges while moving toward more peaceful solutions and a life filled with contentment.

Mission Statement:* *To guide, while utilizing traditional and/or eclectic therapeutic approaches and techniques, clients on their therapeutic journey in acquiring the skills and tools that will enhance overall well-being and peace.

Welcome to my practice! This informed consent document is intended to provide you with important information about my professional services and business policies. This is a legal document and after signing this document, it also represents a legal agreement between us; please read it carefully. We can discuss any questions presently and any that you may have in the future.

Introduction:

As a Licensed Certified Social Worker- Clinical, I am bound by my professional ethics to ensure that you understand the therapeutic relationship that will evolve between myself as the "therapist" and you as my "client" that works in part based on clearly defined rights and responsibilities that are held between us. There are legal limitations to the rights within our relationship, and I as well, have corresponding responsibilities to you. These rights and responsibilities are described below.

Psychological/Psychotherapy: _____ (Initials)

Please understand that psychotherapy has benefits and risks. Risks may include, but is not limited to the following list of experiences: uncomfortable feelings (i.e. sadness, guilt, anxiety, anger, frustration, loneliness, helplessness. You may experience these feelings because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has also been shown to have benefits for those who undertake this journey and process. Therapy can lead to a significant reduction in feelings of distress, increase satisfaction in interpersonal relationships, greater personal awareness and insight, increased ability to manage stress and resolve specific problems. But there are no guarantees about what will happen.

My motto: “You get out, what you put into it.” Psychotherapy requires active participation and effort from both parties.

“I, _____ (name/signature), agree to come to sessions, display a willingness to participate in verbal and/or nonverbal exercises, and work on things (such as homework assignments) we have discussed in our sessions, outside of our sessions.”

The first 1-3 sessions will involve a comprehensive evaluation of your needs. Please be aware that I may present a series of questions that will assist me in formulating a more holistic and just approach to support your treatment needs. During these sessions, I will be able to offer to you some initial impressions of what our work could consist of. We will discuss your treatment goals and draft an initial treatment plan. Your treatment plan will include a diagnosis from the **DSM V: Diagnostic and Statistical Manual of Mental Disorders**. At this time, feel free to ask questions regarding this therapeutic process, including logistical, procedural, or policy-related questions that will support your treatment.

Appointments:_____ (Initials)

Appointments will ordinarily be 45-50 minutes in duration, weekly or biweekly at a mutually agreed upon time block, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount of your co-payment [unless we both agree that you were unable to attend due to circumstances beyond your control]. Insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. Remember, it is important that you attend your sessions on time; if you are late, your appointment will still need to end on time.

Professional Fees:_____ (Initials)

You are responsible for paying at the time of your session unless prior arrangements have been made. Payments can be made by cash, check, or credit card. Any checks returned to my office are subject to an additional fee of up to $25 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

Insurance: _____ (Initials)

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent

possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of healthcare, insurance benefits have increasingly become more complex. it is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without this they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits have terminated. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

As mentioned earlier **(under Psychological/Psychotherapy section)**, you should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (A clinical diagnosis is a technical term that describes the nature of your problems and whether they are short or long-term problems. All diagnoses come from a book called the **DSM-V** which stands for **Diagnostic and Statistical Manual for Mental Disorders**. There is a copy of the DSM-V in my office and I will gladly let you see it to learn more about your diagnosis, if applicable)

Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do once they have the information. In some cases, they may share the information with a national medical information database. I will provide you with a copy of any report I submit, at your request. By signing this agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called **co-insurance)** or a flat dollar amount (referred to as **co-payment**) to be covered by the patient. Either amount is to be paid at the time of the visit by check, cash, or credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the client before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once

we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you or aid in finding an in-network provider.

Other fees/Charges: _____ (Initials)

Fees for court appearances, phone sessions, copies of records, etc. will be discussed with you if the need arises. Phone consults initiated by the client, that exceed 10 minutes will be billed in quarter hour increments based on the per session fee.

Professional Records: _____ (Initials)

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you attended/did not attend the session, reason for seeking therapy, the goal that was worked on and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have the right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that copy of your file be made available to another health care provider at your written request.

Confidentiality: _____ (Initials)

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled ***Notice of Privacy Practices***. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

Contacting Me: _____ (Initials)

I am often not immediately available by telephone. I do not answer my phone when I am with other clients or otherwise unavailable. At these times, you may leave a

voicemail message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. You may also text or email me but please do not place confidential (private) information in your text/email message. If, for any number of unforeseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, **1)** go to your local hospital's Emergency room, or **2)** call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences. Any excessive or unwarranted use of my contact information may lead to services being terminated at which time you will be given several outside referral sources for you to continue your therapy.

Other Rights: _____ (Initials)

If you are unhappy with what is happening in therapy, it is my hope that you will talk

with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, free of discrimination as to race, ethnicity, color, gender, sexual orientation/identity, age, religion, national origin, physical ability, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Consent to Psychotherapy:

Your signature below indicates that you have read, understand, and consent to this Agreement and the Notice of Privacy Practices and agree to their terms. I also understand that have had the opportunity to ask questions about and understand all of these policies.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority