Informed Consent to Psychotherapy with a Pre-Licensed Provider

Please read this document carefully. Your signature means that you understand and agree to the terms of psychotherapy services provided through Dr. Jackie Jiang & Associates, LLC by a supervisee, intern, trainee, associate-level clinician, or other provider working under clinical supervision.

1. Provider Status and Supervision

I understand that the provider is not independently licensed to provide psychotherapy without supervision, unless otherwise specifically stated in writing. The provider is offering services under clinical supervision through Dr. Jackie Jiang & Associates, LLC. I understand that my case may be reviewed in supervision for treatment planning, clinical guidance, documentation review, legal and ethical compliance, risk management, billing/insurance compliance, and quality of care. This may include discussion of my symptoms, diagnosis, treatment goals, progress, safety concerns, records, and other clinically relevant information. Supervision is part of the treatment process. Information discussed in supervision remains confidential within the limits described in this consent.

2. Nature of Therapy Services

Psychotherapy is a professional mental health service intended to address emotional, behavioral, relational, adjustment, parenting, stress-related, trauma-related, developmental, attention-related, or other mental health concerns within the provider's scope of training and competence. Therapy may include discussion of thoughts, emotions, behaviors, family issues, coping skills, communication, parenting strategies, emotional regulation, treatment goals, and progress toward those goals. Therapy requires active participation. Benefits are possible, but no specific result is guaranteed. Therapy may also involve emotional discomfort, including sadness, anxiety, anger, frustration, or distress when difficult issues are discussed. I understand that I may ask questions about treatment at any time and may request a referral if I believe another provider would better meet my needs.

3. Services Not Provided Under This Consent

I understand that psychotherapy with a supervisee / pre-licensed provider is not psychological testing, forensic evaluation, custody evaluation, parenting-time evaluation, disability evaluation, fitness-for-duty evaluation, court-ordered evaluation, or expert witness service. The provider will not provide forensic opinions, custody opinions, parenting-time recommendations, disability opinions, fitness-for-duty opinions, legal opinions, or psychological testing reports under this consent. If I need those services, I understand I must obtain them separately from an appropriately qualified provider.

4. Confidentiality

Information shared in therapy is confidential and will not be released without proper written authorization, except as allowed or required by law. Mental health records and communications are protected under applicable federal and state privacy laws, including HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110.

Limits to confidentiality may include, but are not limited to: suspected abuse or neglect of a child, elderly person, or dependent adult; serious risk of harm to self or others; medical or psychiatric emergency; court order

or other legal requirement; insurance billing, audit, authorization, or payment review; consultation or supervision for treatment purposes; and other situations required or permitted by law.

I understand that office staff may access limited information necessary for scheduling, billing, insurance, payment, recordkeeping, and office operations. Staff are required to maintain confidentiality. If treatment records involve substance-use-disorder treatment information protected by 42 CFR Part 2, I understand that additional protections may apply and that a separate written authorization may be required before those records can be disclosed.

5. HIPAA Notice of Privacy Practices

I acknowledge that I have been offered or provided access to Dr. Jackie Jiang & Associates, LLC's Notice of Privacy Practices, which explains how health information may be used and disclosed and describes client rights regarding protected health information.

6. Minors and Parents/Guardians

For clients under age 18, a parent or legal guardian generally must consent to treatment unless Illinois law allows the minor to consent independently in a specific situation. Illinois law allows minors age 12 or older to request and receive outpatient counseling or psychotherapy without parent/guardian consent under limited circumstances. The office will evaluate each minor-consent situation individually and may require parent/guardian consent, legal documentation, or supervisor review before treatment begins or continues.

For minor clients, parents/guardians may have access to certain information as allowed by law, including general information about the minor's condition, diagnosis, treatment needs, services provided, and safety concerns. At the same time, the provider may maintain appropriate privacy for the minor when clinically appropriate and legally permitted.

If a minor client turns 18 during treatment, the client becomes responsible for consenting to continued treatment and authorizing any further parent/guardian involvement or access to records.

If parents are separated, divorced, or involved in custody, parenting-time, or decision-making disputes, the office may require documentation of legal decision-making authority before treatment begins or continues. The office may require consent from both parents when legally or clinically appropriate.

The signing parent/guardian represents that he or she has legal authority to consent to treatment for the minor client and agrees to provide accurate and current information about custody, guardianship, parenting-time restrictions, orders of protection, decision-making authority, and any court orders affecting consent for treatment.

7. Couples, Family, Parent-Child, or Conjoint Therapy

If therapy involves more than one participant, I understand that confidentiality works differently than in individual therapy. The provider may need to share clinically relevant information among participants when necessary for treatment.

The provider does not agree to keep secrets between participants when doing so would interfere with treatment, safety, legal duties, or clinical integrity. If a participant shares information privately that is clinically significant

to the conjoint treatment, the provider may require that the information be addressed in treatment, may pause services, may refer one or more participants elsewhere, or may end conjoint treatment if appropriate.

8. Therapy and Legal/Custody Disputes

Therapy is not intended to gather evidence for legal, custody, parenting-time, divorce, disability, employment, or court purposes. Treatment records may not support the legal position of either parent, party, client, employer, attorney, or agency.

I understand that the provider and Dr. Jackie Jiang & Associates, LLC do not agree to become involved as expert witnesses through this therapy relationship. If records are subpoenaed or requested for court, the office may object, seek legal guidance, or respond as required by law.

9. Appointments, Cancellation, and Attendance

Therapy appointments are scheduled in advance. Clients are expected to attend appointments on time. If I cannot attend an appointment, I must provide at least 24 hours' notice. If I miss an appointment or cancel with less than 24 hours' notice, I may be charged a $50 late-cancellation/no-show fee unless a lower fee is required by law, payer contract, office policy, or my written fee agreement. For sliding-fee clients, the missed-appointment fee will not exceed the client's agreed session fee. Insurance is not billed for missed appointments, and the client is personally responsible for any applicable missed-appointment fee unless prohibited by the payer or law. The practice may waive the fee in documented emergency or extenuating circumstances. If I miss two consecutive scheduled appointments, my remaining scheduled appointments may be cancelled, and I may need to contact the office to resume scheduling.

10. Fees, Insurance, and Payment

I understand that I am responsible for payment of copays, coinsurance, deductibles, self-pay fees, sliding-scale fees, missed appointment fees, and any charges not covered by insurance.

Payment is due at the time of service unless other written arrangements have been made. Insurance coverage is not a guarantee of payment. If insurance denies payment, I may be responsible for the balance as allowed by law and by my insurance contract.

For therapy services provided by a supervisee / pre-licensed provider, the office may bill only insurance plans that allow services to be provided under supervision. Depending on the insurance plan, services may be billed under the supervisor's credentials, the group practice, or another allowed billing arrangement. Some insurance plans do not cover services provided by supervisees or pre-licensed providers. Clients may ask the office about insurance coverage for supervisee services before treatment begins, but benefit verification is not a guarantee of payment. If my insurance does not cover these services or later denies payment, I may be responsible for the balance as allowed by law, payer contract, and my written financial agreement.

11. Communication and Emergencies

The office phone number is 309-944-7833. This number is for scheduling, billing, routine questions, and non-emergency communication. This office does not provide 24-hour crisis services. If I am experiencing a life-threatening emergency, serious risk of harm to myself or someone else, or a mental health crisis requiring immediate help, I agree to call 911, go to the nearest emergency room, or call/text 988. I understand that email,

voicemail, text, portal messages, and other electronic communication may have privacy risks and should not be used for emergencies.

12. Ending or Transferring Therapy

I may end therapy at any time. The provider, supervisor, or practice may recommend ending or transferring therapy if treatment is no longer clinically appropriate, if my needs are outside the provider's scope of training or competence, if payment issues remain unresolved, if attendance is inconsistent, if safety concerns require a higher level of care, if supervision requirements change, if the supervisee leaves the practice, or if another provider would better meet my needs. The provider, supervisor, or practice will take reasonable steps to avoid client abandonment and will provide referrals, transition recommendations, or other clinically feasible transition support when services are ended by the provider, supervisor, or practice.

13. Client Acknowledgment and Consent

By signing below, I acknowledge that I have read and understand this consent form. I have had the opportunity to ask questions. I acknowledge that I may request a copy of this consent form for my records. I consent to receive psychotherapy services from the supervisee / pre-licensed provider named below under supervision through Dr. Jackie Jiang & Associates, LLC.

Client Name	Client Signature	Date
Parent/Guardian Name	Parent/Guardian Signature	Date
Provider Name	Provider Signature	Date
Supervisor Name	Supervisor Signature, if required	Date