**Informed Consent for Psychotherapy**

**General Information:**

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing and dating at the end of this document.

**The Therapeutic Process:**

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

**Confidentiality:**

The session content and all relevant materials to the client’s treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert’s report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

**About the Clinician**:

I specialize working with individuals in counseling.  I can also work with couples and groups.  I am trained to use Logotherapy and Cognitive Behavioral Therapy in assisting clients achieve mental health, wellness, education and career goals.  I can use a variety of other modalities and techniques as well, to best serve clients who respond better to other counseling approaches.

I am a Licensed Professional Counselor (LPC-7326) in the State of Idaho.  I have obtained a Master’s Degree in Clinical Counseling with an emphasis in Logotherapy from Northwest Nazarene University.  My education and experience have prepared me to work with individuals, couples, children, adolescents, adults and groups. I do not typically work with minors, my preference is to refer them to counselors who specialize with their age groups.

My contact hours are Monday-Wednesday from 7 AM until 9 PM and Thursdays from 8 AM to 4 PM. I am unavailable outside of those days and times. If you experience a life-threatening crisis, you agree to contact 911, go to the nearest emergency room and/or contact the Crisis Hotline at 988.

**PRACTICE POLICIES**

**DURATION OF TREATMENT:**

There are a great many variables that will impact the length of treatment for mental health concerns. Some clients only require a few sessions to get them on track to where they are comfortable tackling challenges on their own. Some clients are more entrenched in maladaptive behavior and thought patterns, requiring more help getting to where they want to be. In both cases, people who are intentional and active in pursuing change tend to have better outcomes. I am happy to meet with you for as brief or as long as is desired, however there must be active goals we are working towards. The client will have the opportunity to collaborate on creating treatment plans to best serve their current interests or situation. In all, it is impossible to accurately predict how many sessions are appropriate for any given client on any given issue.

**INSURANCE:**

If you have a health insurance benefits policy, it may provide some coverage for mental health treatment when a licensed professional provides such treatment. I will provide you with assistance to facilitate your receipt of the benefits to which you are entitled, including completing insurance forms as appropriate.

However, **you** *(not your insurance company)* **are responsible for full payment of the fee.** Carefully read the section in your insurance coverage that describes mental health services and call your insurer if you have any questions. Some managed health care plans such as HMOs and PPOs may require advance authorization before they will provide reimbursement for mental health services. It may be necessary to seek additional approval after a certain number of sessions.

Please be aware that most insurance agreements require you to authorize me to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plans or summaries, or in rare cases, a copy of the entire record. This information will become part of the insurance company’s files. It is important to remember that you always have the right to pay for counseling services yourself if you prefer to avoid involving your insurer.

**SCHEDULE OF FEES:**

Diagnostic session: $150

1 hour session: $140

45-minute session: $100

30-minute session: $70

Scholarship 1 hour: $75

Scholarship 45-minute: $50

I offer scholarships for people who have made a life in service to their communities (military, police, teachers, etc.) and either do not want to use, or do not have, insurance. ***If you are 15 minutes late or more, the session will be cancelled as a no show/no call and be subject to the cancellation fee. This fee is paid by you, not your insurance.***

**APPOINTMENTS AND CANCELLATIONS:**

Please remember to cancel or reschedule the day before your appointment. *THE AUTOMATIC REMINDERS ARE FROM AN UNMANNED ACCOUNT, PLEASE CONTACT YOUR COUNSELOR DIRECTLY FOR CANCELLATIONS.* You will be responsible for half my billable rate of $140 if the cancellation is the same day as your appointment.

The standard meeting time for psychotherapy is 53 minutes, the other 7 minutes is for billing and record keeping. It is up to you, however, to determine the length of time of your sessions. Requests to change the 53 minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

A $10.00 service charge will be charged for any checks returned for any reason for special handling.

**Cancellations and no show/call will be subject to a $70 fee** ***IF NOT RECEIVED BY THE DAY BEFORE YOUR APPOINTMENT***. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

TELEPHONE ACCESSIBILITY: If you need to contact me between sessions, please leave a message on my voice mail or send me a text. I am often not immediately available; however, I will attempt to return your message within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. I do not make myself available for emergencies.

If a true emergency situation arises, please call 911, any local emergency room or call the crisis hotline. I am also not available to my clients from Friday through Sunday.

SOCIAL MEDIA AND TELECOMMUNICATION: Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients or client’s family members 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.

ELECTRONIC COMMUNICATION: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment,

you need to understand that:

(1)You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine.

Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

**RECORD KEEPING:**

Both law and the ethical standards of the counseling profession require that I keep treatment records. You are entitled to receive a copy of these records. If you wish to see them, I may prefer to prepare an appropriate summary instead. Client records are professional documents; they can be misinterpreted and can be upsetting. If you insist on seeing your records, it is best to review them with me so that we can discuss their content. Clients will be charged an appropriate fee for any preparation time that is required to comply with an informal request for record review. If you are under 18 years of age, the law provides your parents/Guardians the right to examine your treatment records. If you are over the age of 14, you must give written approval for these records to be released. Your records will be kept for 7 (seven) years after termination of counseling services. For minors, 7 (seven) years after the minor turns 18 (eighteen).

In the event of incapacitation or death of a client, the treating clinician will maintain the confidentiality of all records, except as outlined in limits of confidentiality. In the event of incapacitation, death or termination of treating clinician, the client become the designee of all personal records wherein they are the primary client.

**MINORS:**

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you, and your parents, what information is appropriate for them to receive and which issues are more appropriately kept confidential.

**TERMINATION:**

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued***. If you do not maintain at least 66% attendance to scheduled appointments, I reserve the right to discontinue services***. I will then provide you a referral list to aid in your search for a new counselor.

**COMPLAINT PROCESS:**

Should you have a complaint regarding your treatment, please bring it to my attention so that I may attempt to rectify the issue first. If I am unable to rectify the situation, I will work with you to find an appropriate clinician to meet your counseling needs.

If you feel that you wish to file a complaint regarding my professional services, you may download a Complaint Form from the state licensing board at <https://dopl.idaho.gov/> or you may also request a mailed copy of the Complaint Form by contacting the Idaho Division of Occupational and Professional Licenses (DOPL) or by e-mailing the Investigative Unit (Occ-Inv@dopl.idaho.gov). A written and signed statement of your complaint is required before an investigation can begin. You may fill out an DOPL Complaint Form online, print & sign the

form, attach copies of any documents which relate to the problem, and mail it to the DOPL office.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_