760 Central Street Unit #3
Franklin, NH 03235
(802) 523-3517

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 filling in the checkbox 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.

FINANCIAL AGREEMENT

Thank you for choosing Goodwin Counseling Services LLC to assist you. This is our financial policy which we hope will answer any questions you may have, and will specify the financial contract for our work together.

Our fees are as follows: Initial Evaluation Session - $200.00; Individual, couples and family therapy - $150.00. Depending on circumstances a reduced rate may be offered.
If you are using insurance, we may have contractual agreements with your insurance company to accept a different fee. Prior to your first session we will contact your insurance company to determine benefits, authorization, co-pay and if a referral is required. We CANNOT GUARANTEE the accuracy of the information we receive.

We recommend that you contact your insurance company to confirm this information as you will be responsible if there is any difference in actual reimbursement. Additional charges apply for writing reports, court appearances and telephone consultations when these are needed. We will discuss fees and your co-payment at or before your first session.

1. Client fees and insurance co-payments are due at the time of service. Your prompt payment is appreciated. For your convenience, we accept Cash, Visa and Mastercard, American Express, Discover and Care Credit.
2. Bills that are over 90 days overdue may be forwarded for collections.
3. Our office will print your insurance claims for you to submit if needed for out of network benefits.
4. **Late Cancelation/Missed appointments:** Appointment times are reserved for you by your therapists. Appointment must be cancelled at least 24 hours prior to the scheduled appointment time or be subject to the late cancelation/missed appointment fee. We cannot bill insurance companies for missed appointments therefore you would be responsible for the full fee for missed session.

Goodwin Counseling Services LLC
Psychotherapy

Late Cancelation/Missed appointment Fees-

- ***1st late cancel/missed appointment** – $80 fee charged, conversation/review of cancellation policy*
- ***2nd late cancel/missed appointment** $115. fee charged, conversation about termination of therapy*
- ***3rd late cancel/missed appointment,** $150. fee charged, termination of therapy*
- If there are extenuating circumstances due to illness, injury, or emergency, the clinician may take this into consideration and advocate for a lesser fee.

If you intend to use your health insurance carrier for these mental health services, please note the following: In order to submit a claim, we are required to give you a psychiatric diagnosis. Additionally, many carriers require that we provide a detailed treatment plan containing: your symptoms, reasons for treatment, your progress, and information that describes the seriousness of your condition. You should understand that this information is stored in electronic databases that are accessed by other insurance companies. Once this information is disclosed, Goodwin Counseling Services LLC cannot guarantee your confidentiality.

Our financial agreement with you is one aspect of our therapeutic relationship. You have our commitment to your healing and well-being and this includes our willingness to form a financial contract with you that will be mutually agreeable. Please read and sign this original. We will give you a copy for your files. We understand that financial problems may occur, if so please discuss this with your therapist.

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

Date: ______________

Patient Name Printed: _____________________________________

Parent/Guardian Name Printed: _____________________________________

Parent/Guardian Signature: ____