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# INFORMED CONSENT FOR THERAPY SERVICES

Therapy is a relationship between people that works because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. To be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan.

You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you find a different therapist by sharing the list of community mental health providers in our area.

## TRAINING AND DEGREES

I am a Licensed Clinical Professional Counselor with a Master of Educational Counseling Degree from University of Anchorage, Alaska. I have over 30 years of clinical experience in counseling. I earned thousands of hours learning from other incredible clinical doctors and therapists. I am licensed in Idaho and Montana. I began as a teacher but soon learned my gift was on a deeper level. So after one year of teaching, I enrolled in a Master’s in Counseling program. I have worked in residential settings, hospitals for suicidal youth, Juvenile Justice and other. My specialty is working with difficult cases involving youth and suicide or behavioral challenges. I also enjoy working with adults and children.

## APPOINTMENTS

The first appointment is 60 minutes, all subsequent appointments will ordinarily be 45-60 minutes in duration, once per week at a time we agree on, although some sessions may be 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 of notice. If you miss a session without canceling, or cancel with less than 24-hour notice, my policy is to collect the full amount of a session ($200.00) unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the fee as described above. I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

If you are sick, please call 208 -719-1854 to notify me as soon as you can, I will also return he same courtesy.

# TELEHEALTH

Telehealth may be an option in certain circumstances. In my practice I believe face to face therapy lends to a better therapy experience however, If there are situations that need us to use telehealth I use Google Meet, as it’s the most secure and HIPAA approved. You must be in a setting at home that gives you full privacy. Headphones and show the room before we begin. It is your privacy and mine that are at risk during Telehealth.

# PROFESSIONAL FEES

Standard fees for a client’s initial session and assessment are $225.00 and each subsequent session is $200.00. The client is responsible for paying at the time of session. Payment must be made via cash or credit. If I am credentialed with your insurance company, I will bill your insurance The co-pay is due at the time of service. If the insurance company chooses not to cover the sessions, the full amount of the session is due ASAP. My goal is to offer excellent care to our community and one way to do this is not to spend time working on billing.

In addition to weekly appointments, it is my practice to charge my hourly rate (including travel time) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

# INSURANCE

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, 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.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems). All diagnoses come from a book entitled the DSM-V TR. There is a copy in my office, and I will be glad to let you see it to learn more about your diagnosis, if applicable). Sometimes I must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

# PROFESSIONAL RECORDS

I am required to keep records of the services provided. Client records are maintained in a secure location in the office including but not limited to, brief records noting reasons for seeking therapy, goals and progress set for treatment, client diagnosis, topics discussed, client medical, social, and treatment history, records received from other providers, copies of records sent other providers medical offices and billing records.

# LONG TERM RECORD CUSTODY

In the event I become incapacitated or die, I have a professional agreement with Barb Perusse, LCPC, who will accept professional responsibility for keeping and administering my records in compliance with this agreement and State of Idaho Licensing requirements.

# CONFIDENTIALITY

Our 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 to sign and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

# PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. Any communication will require the child’s agreement, unless I feel there is a safety concern (see also above section on

confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

# CONTACTING ME

My business hours in office are Monday thru Wednesday 10:00 a.m. to 6:00p.m. Phone hours are flexible on an as needed basis. Other appointment times may be available in certain situations. I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail 208-719-1854 and your call will be returned as soon as possible. If, for any number of unseen 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, please go to your Local Urgent Care Services 208-263-0649, the Hospital Emergency Room

208-263-1441, dial 911 or 988. If you are an Optum Member, call the crisis line

1-855-202-0983. I will inform you in advance of my planned absences and provide you with the name and phone number of the mental health professionals covering my practice.

# OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns and meet your needs. 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 receive considerate, safe, and respectful care, without discrimination as to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, 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 ever have social or sexual relationships with clients or with former clients.

# CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

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Signature of Patient or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient or Personal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Informed Consent for Adult Psychotherapy 2017

Adapted from the Center for Ethical Practices