Informed Consent for Psychotherapy Services

Psychotherapy Services

During the first session(s), an evaluation will be conducted to assess your current difficulties, previous history, and reasons for seeking therapy at this time. By the end of the evaluation, I will be able to offer you general treatment recommendations, which may include an initial treatment plan for our work together or referral information for a mental health provider who would be better able to meet your needs. During the evaluation, it is important for you to assess how comfortable you feel working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures or recommendations, we should discuss them whenever they arise. If you decide that you would rather not enter treatment with me, I will be happy to provide you with referral information for other mental health professionals.

There are both potential risks and benefits that can come from participating in psychotherapy. Psychotherapy is a process that requires a commitment from both you and I. In general, this process works best when there is trust on both sides that therapy sessions will occur as regularly and as consistently as possible. Throughout your treatment, you may experience a lot of different types of feelings (like sadness, anger, guilt, frustration, and helplessness) and you may have difficult thoughts, feelings, and memories surface. Some people may experience this as "feeling worse before it gets better," at least for a short period. However, the surfacing of these experiences is often crucial to the therapeutic process and we can find ways of working through them together. Additionally, many people experience several positive benefits from participating in therapy, especially after several sessions. Some benefits may include, overall symptom or distress reduction, improved relationships and daily functioning, a greater sense of meaning or fulfillment in life, and an increase in self-awareness and understanding. There are no guarantees about what you will experience and it is important to discuss these experiences with me, along with any concerns you may have.

Confidentiality

In general, the confidentiality of all communications between a patient and a therapist is protected by law. I can only release information about our work to others with your written permission. However, there are some exceptions and situations in which I would be legally required to take action that might necessitate revealing information about a patient's treatment. Following are some important limitations to confidentiality:

- □ **Duty to Warn and Protect**
  When a client discloses intentions or a plan to harm another person, I am required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, I am required to make reasonable attempts keep you safe and to notify the family of the client.

□ **Abuse of Children and Vulnerable Adults**
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, I am required to report this information to the appropriate social service and/or legal authorities.

□ **Court Order**
If subpoenaed by a judge, I may be required to release you records or testify according to law.

□ **Minors/Guardianship**
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. In the state of Pennsylvania, a child age 14 or old is legally able to consent for his or her own treatment. This means the minor who is 14 years or older has legal ownership of all medical records, regardless of who is paying for the services, and a written consent is required to release his or her medical records. It is my policy to discuss the limits of confidentiality with a client who is a minor and his or her parents at the beginning of treatment and to determine the extent to which information about treatment will be shared with parents or guardians.

□ **Insurance Providers** (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Fees:
In addition to the fees for psychotherapy sessions or evaluations, other billable services may include communications outside of session, report writing, providing copies of medical records or treatment summaries, attending meetings with other professionals on your or the client's behalf, and time spent performing other services you request at my discretion. Please see the "Agreement to Pay" form for further information and discuss any concerns you have with me as they arise.

Please also note that if you anticipate litigation involvement, it may be in your best interest to work with a provider more experienced and specialized in the handling of legal or court-related issues. I will be happy to provide such referral. If you do become involved in legal proceedings and my participation is required (either by you or a third-party), you will be expected to pay my standard rate for all of my professional time, which can include but is not limited to, time for consultation with attorneys, report preparation, and time waiting to testify and actual testimony. If you are using health insurance to cover the costs of your services, please be aware insurance will not cover any of these additional billable services.

Contacting Me:

My individual, professional phone number will be provided to you for you to contact me regarding scheduling issues and in the case of emergencies. However, please note I am typically not immediately available but will do my best to contact you at my earliest availability. If this is an emergency and you cannot reach me immediately, please call the main number at (215) 399-4128 and leave a message indicating your current crisis and the on-call provider will call you back. If you cannot wait for a return call, please go to your nearest emergency room, call 9-1-1, or the Philadelphia 24-Hour Crisis Hotline number at (215) 686-4420.

Finally, please do not hesitate to ask questions as you read this consent form. Once you sign this document, it will serve as our contract for outpatient psychological services.

I have read this document and agree to its terms.

****For parents or guardians, by signing this form I am stating that I have the legal right and ability to provide informed consent for this child.*

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Therapist Date

Acknowledgement of Receiving Notice of Privacy Practices
Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and me, _____. When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____.

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.

If you do not sign this form agreeing to my privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, you can get a copy by directly asking me for it.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked.

After you have signed this consent, you have the right to revoke it by writing to our privacy officer, Kaycee Beglau, PsyD. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_____ _____
Signature of Client or his/her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____ January 1, 2016
Signature of authorized representative of this practice Date of NPP

□ Copy given to the client/parent/spouse/representative