The Works Counseling Center

PROGRESS NOT PERFECTION

INFORMED CONSENT TO TREATMENT

Introduction

Welcome to The Works Counseling Center. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so we can discuss them. When you sign this document, it will represent an agreement between us.

Confidentiality

In general, the law protects the privacy of all communications between a client and a therapist/psychologist/psychiatrist, and I can release information about our work to others only with your written permission. All aspects of your treatment are confidential, and I will need your written permission if you wish me to discuss your treatment with anyone else, including your insurance company. Even the fact that you are a client in my practice is protected by confidentiality. All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information.

However, it is important that you know that your therapist utilizes a “no-secrets” policy when conducting family or marital/couples’ therapy. This means that if you participate in family, and/or marital/couples’ therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her “no secrets” policy and how it may apply to you. In addition, periodic consultation with peers regarding specific case questions is an accepted and important part of psychotherapeutic practice in order to give you the best care. All information is kept confidential and anonymous. Please let me know if you have concerns about this.

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the

patient that the FBI sought or obtained the items under the Act. All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. Please see the "Notice of Privacy Practices" for more information and a detailed listing of the exceptions to confidentiality.

THERAPY PROCEDURES

INTAKE SESSION:

The intake session will last 50 minutes but can extend to additional sessions. Typically, during the first session, we will discuss your reasons for seeking treatment and basic background information about you. Policies, fees, and scheduling will also be discussed in this meeting. To the extent possible, I will offer you some first impressions of what our work will include. You should evaluate this information along with your own opinions to determine whether you feel comfortable working with me. Therapy involves a noteworthy commitment of time, money, and energy. You should be very thoughtful about the therapist you select. If you have questions or doubts about participating in therapy at the present time or specifically with me as your therapist, please talk to me about your concerns. I will be more than happy to help you set up a meeting with another mental health professional for a second opinion.

Psychotherapy can have benefits and risks. Engaging in therapy often involves discussing unpleasant aspects of your life. Therefore, you may experience uncomfortable feelings like frustration, sadness, guilt, anger, loneliness, and helplessness. On the other hand, psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors. Consequently, you may benefit by minimizing your overall distress, learning more effective problem-solving strategies, and experiencing more rewarding interpersonal relationships.

CONTINUING THERAPY SESSIONS:

Frequency of counseling sessions will be determined by the severity of your presenting symptoms, your treatment goals, and agreed upon treatment plan. Counseling sessions are generally scheduled once a week, and may be reduced in frequency as your progress in treatment. A given hour is considered blocked for a particular client; this hour is comprised of 45 to 50 minutes of psychotherapy and 10 to 15 minutes of administrative procedures (i.e., note-taking, phone calls, insurance claim submissions).

ENDING THERAPY:

My goal is to provide a quality service in the shortest period of time that is necessary for you to derive benefit from the therapy. You have the right to withdraw from treatment for any reason at any time. I ask that you agree to have a final session after you notify me of your voluntary termination of treatment, so that I may responsibly review and evaluate your reasons, and make recommendations related to the termination of treatment.

ABOUT THE THERAPY PROCESS

It is your therapist's intention to provide services that will assist you in reaching your

goals. Based upon the information that you provide and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. Therapists and patients are partners in the therapeutic process and you have the right to agree or disagree with your therapist's recommendations and your feedback regarding your progress is strongly encouraged. Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

ELECTRONIC COMMUNICATION AND CONSENT FOR USE

Be advised that the use of email, cell phone texting, and other forms of technology in psychotherapy may have security concerns and have not been defined as a best-practice strategy.

Any information exchanged electronically or with the use of technology increases the risk of confidentiality breaches. Communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Therefore, the therapist cannot guarantee protection from unauthorized attempts to access, use, or disclose personal information exchanged electronically. Do not include personal identifying information such as your birth date, or personal medical information in any emails you send.

Email/texting communication with any therapist at The Works Counseling Center will be used for the purpose of simplifying and expediting scheduling/administrative matters only. You should also know that any electronic communication I receive from you and any responses that I send to you may become a part of your legal medical record.

Email/texting communication is NOT to be used to provide/receive treatment services or take the place of therapy sessions. Therefore, email/texting should NOT be used to communicate: Suicidal or homicidal thoughts or plans, urgent or emergency issues, serious or severe side effects or concerns, or rapidly worsening symptoms. In a life-threatening emergency client should: Call 911, proceed to the nearest hospital emergency room, and/or call a crisis hotline such as 855-274-7471 or 1-800-SUICIDE. No one can diagnose your condition from email or other written communications, and communication via a website cannot replace the relationship you have with your mental health practitioner. The use of email, cell phone, or other forms of technology does not change the fact that the service provided by any therapist at The Works Counseling Center are weekly psychotherapy sessions scheduled and confirmed by both parties in advance of the sessions. The Works Counseling Center does not provide crisis intervention, and email/cell phone texting is not a reliable way of obtaining urgent help from the therapist in an emergency.

I have thoroughly considered all of the above information. By signing the Client Information form I consent to the use of email/cell phone texting as needed for scheduling and administrative purposes only, within the guidelines above. If more urgent help is needed, I will utilize the crisis services listed above. Furthermore, if at any time my therapist or I believe email/texting is interfering in my therapeutic process or being used ineffectively, either of us can revoke this consent verbally, refuse to respond to emails/texts, and insist upon a verbal conversation before proceeding.

BILLING AND PAYMENTS
Payment is due at the time of service, unless we agree otherwise. Cash, check, or credit cards are acceptable forms of payment. A credit card is required to be kept on file to hold all scheduled appointment times. Missed sessions (including sessions cancelled within 24 hours) will be charged to the credit card on file.

CREDIT CARD AUTHORIZATION:

Your signature authorizes The Works Counseling Center to charge your credit card for all sessions, late cancellations, missed appointments, and outstanding balances (over 60 days):

Payment Method: (Please Circle)

MASTERCARD VISA AMERICAN EXPRESS DISCOVER HSA

Credit Card Number: _____

Print Name as It Appears on Credit Card: _____

Zip Code: _____ Security Code: _____

Expiration Date: _____ /_____

Email Address for Receipts _____

Authorization Signature _____
Date_____

By signing this agreement, you are confirming that you understand that it is your responsibility for full payment of our fees. Further, you confirm that you understand that it is your responsibility to:

- pay, at the time services are rendered, the agreed upon session fee;
- provide current mailing address and phone numbers, as well as notification when there are any changes to this information

COMPLAINTS
It is our hope at The Works Counseling Center to resolve any misunderstandings that

may arise by discussing them with you. Working through such difficulties is one of the most effective ways to grow psychologically and emotionally. Please call and speak with the Administrative Director, to file a complaint against one of the therapists. However, should you have a complaint that you cannot resolve by talking with the director, the active therapist, or that you do not care to discuss with us, you have the right to call the Tennessee State Board for Licensed Professional Counselors, Licensed Marital and Family Therapists and Licensed Clinical Pastoral Therapists.

FEES

The fee for service is $125 per individual, marital, or family therapy session unless otherwise agreed upon. Regular sessions are 50 minutes in length though a longer session can be arranged for an additional charge. You are responsible for fees at the time services are rendered. In certain cases, a written agreement that specifies an alternative payment procedure can be determined. If you choose to pay via credit/debit card there will be an additional 3% convenience fee. Fees may increase periodically, and thus the fees are subject to change with one week's prior notification.

CANCELLATION POLICY

24-HOUR CANCELLATION POLICY:

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. Note that this fee is the full cost of the session ($125), and not a reduced rate.

LATENESS:

If you arrive late for a scheduled appointment, only the remainder of the 50-minute session will be available. If I run late with a prior appointment for some reason, you will still receive the full 45 to 50 minutes. It is the office policy, that if you arrive 15 minutes late to your scheduled appointment, without notice, it will be considered a no-show and you will be responsible for the missed appointment fee ($125).

INCLEMENT WEATHER AND CLOSURES:

If there is inclement weather and/or if local schools are closed due to weather conditions, I will do my best to contact you via phone or email if I will not be in the office and may need to reschedule the appointment.

EMERGENCIES

In the event of a life-threatening emergency or a situation that presents imminent risk or harm, call 911 or the Crisis Line at 1-855-274-7471, or go to the nearest emergency room.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT:

_____ *(Initial)* I have reviewed and been provided a copy of the HIPAA notice of privacy practices. I have been given the opportunity to ask questions about these policies, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services.

INFORMED CONSENT TO TREATMENT:

_____ *(Initial)* I have read, understood, and had opportunity to question, and I agree to the above conditions and policies. I agree and consent to participate in behavioral health care services offered and provided at The Works Counseling Center. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

I also permit the use of a copy of this signed authorization in place of the original.

_____ _____

Signature of Patient Date

_____

Print Name

(If family therapy other signatures below)

_____ _____

Signature of Patient Date

_____

Print Name

_____ _____

Signature of Patient Date

_____

Print Name

SPECIAL CONFIDENTIALITY NOTICE FOR PARENTS

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will

encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to Tennessee law, and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children
- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.
- You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.
- In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.
- Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

Parental/Guardian Minor Policies and Consents Collaborative Approach

The involvement of children and adolescents in therapy can be highly beneficial to their overall personal development. Sometimes, it is best to see children with parents/guardians and other appropriate family members. Other times, it is best to see children alone. Often a mixture of the two is required for the child to receive the full benefits of the therapy. Together, parents/guardian, the child, and the therapist, assess which approach is in the best interest for the child. This can change throughout the course of therapy.

THERAPIST'S LIMITED ROLE:

The therapist's role is that of an advocate for the overall emotional and psychological development of the child. Because of the therapist's role as child's advocate, it is in the best interest of the child that the therapist not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist. If requested, the child's therapist can provide recommendations for these services.

PROVIDING CONSENT:

When a minor has parents who are divorced, a copy of the permanent parenting plan must be provided. The parenting plan allocates which parent has final decision-

making authority in the area of mental health care and other areas. When parents have joint decision-making rights regarding their child's mental health care, written consent from both parents for the child is required. Even in cases where one parent has final decision-making authority, it is usually in the child's best interest that consent from both parents is obtained.

I, (parent/guardian)_____ agree that (clients name)_____ should have privacy in his/her/their therapy sessions, and I agree to allow this privacy except in extreme situations, which I will discuss with the therapist. At the same time, except under unusual circumstances, I understand that I have a legal right to obtain this information. To increase the effectiveness of the therapy, I agree to the following:

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of the sessions. If my child prefers/ children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/ children have been abused or is/ are a clear danger to self or others, the therapist will normally tell me only the following:

- Whether sessions are attended
  Whether my child is/ children are generally participating or not
- Whether progress is generally being made or not

The normal procedure for discussing issues that are in my child's/ children's therapy will be joint sessions including my child/ children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/ children present.

Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/ children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/ children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

I understand that my therapist is limited in their scope of practice and does not provide clinical opinions or commentary as to legal issues regarding a child, parent/guardian, or family.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Patient Date