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Informed Consent for Treatment

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you (the client) have so that we can discuss them. When you sign this document, it will represent an agreement between us.

Therapeutic Relationship
Psychotherapy is not easily described in general statements. It varies depending upon the personalities of the therapist and the client and the particular problems you bring forward. There are many different methods I may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, fear, loneliness, anger, frustration, or helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience.

Initial _____

Couples/Family Sessions
Work with couples/families is a special situation. Under these circumstances the entire family unit as a whole is considered to be the client. Generally sessions will include each member of the couple/family, however there may be times when it will benefit therapy to have one or a few sessions with one or more members of the couple/family alone. In these situations, fees will remain the same. Each member of the couple/family is considered to be part of the family system and will be encouraged to consider their role as well as how they can best meet the needs

of the couple/family. It is my policy that I am not a "keeper of secrets" in dealing with couples. Not withholding information is therapeutically important in building trust and repairing relationships. If during treatment, it becomes apparent that I have been told information that is significant to the relationship/treatment that the other member of the couple is unaware of, I will encourage and help you to tell the other member of the couple about this information. If you do not do this on your own within a given time period I will reveal this information to the other member of the couple in session and work through it with both members.

Initial _____

Confidentiality

Information that you share in individual, couples, family or group counseling is confidential unless you sign a Release of Information form to a specific person or agency. Psychotherapists must keep brief written records of each counseling session. Confidentiality of such records and information collected about you will be held and released in accordance with state laws regarding confidentiality of such records and information.

There are some exceptions to these confidentiality laws. Therapists are mandated by law to report the following to the proper authorities:

1. Suspected child abuse or neglect.
2. Suspected elder or dependent adult abuse.
3. Statements or threats pertaining to harming self or other.

I utilize a billing company, Comprehensive Medical Management, and will release only the necessary information to them to complete the billing and claims process. Comprehensive Medical Management also upholds all confidentiality laws with all client information.

At times, therapy will involve the participation of more than one family member and/or significant person(s). Though no information will be revealed without your participation, you understand that there is no guarantee of confidentiality among participants during couples and family therapy sessions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. However, in some proceedings such as those involving child custody, those involving your emotional condition as an important issue or others, a judge may order my testimony if he/she determines that the issues demand it.

I may occasionally find it helpful to consult with other professionals about a case. During consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

Initial _____

Professional Fees

My hourly fee is $175.00. Sessions are 53 minutes in length. In addition to regular sessions, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. This includes telephone conversations lasting longer than 15 minutes per day, report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries and time spent performing any other professional services you may request of me. My fee for my involvement in legal proceedings, such as court appearance, testimony, or other services is $400.00 per hour. These fees are subject to change. All clients will be given adequate notice in writing of any fee changes.

Payment in full is expected at the time services are provided. You may pay by check or cash. Any returned checks will result in a $45.00 service charge, and returned checks will prompt a requirement to pay for future sessions in cash.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collections agency or going through a small claims court. (If such legal action is necessary, its' costs will be included in the claim.) In most collection situations the only information I release involving a patient's treatment is his/her name, the nature of services provided, and the amount due.

Initial _____

Cancellation Policy

If you cannot make your appointment, you must call me at (619) 335-5373, as soon as possible to reschedule, at least 24 hours prior to your scheduled appointment. If you do not give 24 hour notice, you will be charged $45.00 for the missed appointment. Payment will be expected when you attend your next appointment.

Initial _____

Emergency Situations

In the event that you are experiencing an emergency you can reach me, Jan Slack, at 619-335-5373. In the event I am unavailable, you can leave a message for me. I will make every effort to return your call no later than my next working business day. You can also reach the 24 hour Access and Crisis Line at 888-724-7240 in the event of a mental health emergency. If this is any other type of emergency you will call 911. If I will be unavailable for an extended

period of time I will provide you with the name and number of a colleague to contact, if necessary.

Initial_____

Telemental Health

I, _____, hereby consent to participate in telemental health with, Jan Slack, LMFT, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/ or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone: _____

_____ I

have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Termination of Treatment

If at any time during the course of your treatment I determine I cannot continue, I will terminate treatment and explain why this is necessary. Ideally, therapy ends when we agree your treatment goals have been achieved. Additional conditions of termination include:

You have the right to stop treatment at any time. If you make this choice, referrals to other therapists can be provided and you will be asked to attend a final 'termination' session.

Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit. If you are meeting with another therapist, you must first terminate treatment with that therapist before I can begin providing services. If you remain in therapy with someone else and this becomes apparent after we begin, I am ethically required to terminate your treatment.

Other legal or ethical circumstances may arise and compel me to terminate treatment. In these cases appropriate referral(s) will be offered. Also, I do not diagnose, treat, or advise on problems outside the recognized boundaries of my competencies.

Other situations that warrant termination include: regularly becoming enraged or threatening during session; bringing a weapon onto the premises; persistent drug abuse; arriving under the influence of drugs or alcohol; or missing three scheduled sessions without a cancellation phone call.

Initial_____

Office Environment

Please do not use cell phones, laptops, or other electronic devices during session unless directed to do so. If you use them in the waiting area, please be respectful of others in the area and keep items in silent mode. Thank you.

BY SIGNING BELOW, YOU INDICATE YOU HAVE READ AND UNDERSTAND THE ABOVE.

Signature of Client(s) **Date**

Signature of Therapist **Date**