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Informed Consent for Therapy Services

CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Initial here if this section has been read and understood_____

PSYCHOTHERAPY SERVICES

Therapy is a relationship between people that works in part 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. In order 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 set up a meeting with another mental health professional for a second opinion.

Other treatment approaches are available as an alternative, or as an adjunct, to individual psychotherapy. Many of these services I provide to my clients. If you wish to explore treatment outside of my competency, I will assist you in finding resources within the community. Alternative treatments include: group therapy, self-help groups, 12 step groups, medication assisted treatment, expressive therapies (art, writing, psychodrama), cognitive therapy, behavior modification, guided imagery, Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), careful use of hypnosis and guided imagery and nutritional consultation.

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MEDICAL CONCERNS

Your psychotherapist is not a medical doctor and can therefore not recognize or diagnose medical conditions. It is essential that you obtain a medical examination to determine any medical origins of your psychological symptoms, e.g., neurological disorders, endocrinological abnormalities, glucose and insulin imbalances, effects of toxins, infectious disease, gastrointestinal disorders, side effects of medication, etc.

If you appear to be experiencing symptoms that can be relieved by medications, you will be referred to a psychiatrist for consultation.

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APPOINTMENTS

Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less 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 notice. If you miss a session or cancel within the 24-hour window, you are responsible for full payment. If it is possible, 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.

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PROFESSIONAL FEES

The standard fee for each 50 minute session is $120.00. You are responsible for paying at the beginning of your session. Payment can be made by check, cash, debit or credit card. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 5 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. Testimony, court appearance, travel time, and preparation of written documents, meetings, phone consultations in legal proceedings initiated by you or others relating to your case: $200.00 per hour.

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INSURANCE

I am not currently a participating provider for insurance plans, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

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CLIENTS RIGHTS

1. I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. At times, it might be appropriate to receive a summary of records rather than a complete copy of your records. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. Fee is $30/15 minutes of medical record preparations or writing.

2. You have the right to a confidential relationship with me. Within certain legal limits information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

a. Revealing to me active child-abuse or neglect. If a perpetrator is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors. Active physical abuse of a dependent adult or an elder is taking place.

b. If you seriously threaten harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.

c. If you are in therapy or are being tested by order of the court, the results of the treatment or tests ordered must be revealed to that court.

d. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.

e. If you are in a lawsuit claiming emotional harm, the opposing side may subpoena your therapy records.

f. Psychotherapists reserve the right to release financial information to a collection agency, attorney, or small claims court, if you are delinquent in paying your bill.

g. Psychotherapists often consult with other professionals on cases, and teach or write about psychotherapy process while taking great care to disguise any identifying information. Please indicate with your therapist if you wish to place restrictions on consultation, teaching or writing related to your case.

3. You have the right to ask questions about any of the procedures used in the course of your therapy.

4. Should you choose not to enter in therapy with me, I will provide you with names of other qualified professionals whose services you might prefer.

5. You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions:

a. When I believe that therapy is no longer beneficial to you.

b. When I believe that you will be better served by another professional.

c. When you have not paid for the last two sessions.

d. When you have failed to show up for your last two therapy sessions without a 48-hour notice.

e. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request.

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CONTACTING ME & EMERGENCIES

I am often not immediately available by telephone, however, you may leave a message on my confidential voice mail and your call will be returned as soon as possible. If it is an emergency, please contact:

- Emergency Psychiatric Evaluation Orange County- 714- 834-6900 or 1-866-830-6011. This service will mobilize an assessment team that can respond to a psychiatric emergency occurring

anywhere within our community 24-hours a day/ 7 days a week/ 365 days per year. The team will evaluate, make appropriate referrals and transport to local hospital if necessary.

- Mission Hospital Laguna Beach (949) 499-1311 or your local hospital
- National Suicide Prevention Lifeline: 1-800-273- TALK (1-800-273-8255) open 24 hours a day
- Crisis Hotline: (714) 639-4673
- College Hospital Crisis Response Team: 1-800-773-8001 open 24 hours a day
- Domestic Violence Hotline: 1-800-799- SAFE (1-800-799-7233) open 24 hours a day
- Rape Crisis Hotline: 714-957-2737 open 24 hours a day
- Sexual Assault Victim Services: 714- 834-4317

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ELECTRONIC COMMUNICATION: I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I try to return messages in a timely manner, I cannot guarantee an immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. Texting should be used for scheduling appointments only. Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend requests on sites (such as LinkedIn, Facebook, etc.) to respect your privacy.

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OBLIGATIONS OF ADULT PSYCHOTHERAPY CLIENTS:

I understand that I must be open and honest with my therapist, even if doing so is painful or embarrassing. Therapists can only help clients to the extent that they are provided with the whole truth. The desire to get well and function well can only come from the client. Therapists can help clients slowly overcome feelings of hopelessness and helplessness, but progress is more affected by client motivation than any other factor. I understand that doing therapy homework can often facilitate recovery.

Painful emotions and memories of painful experiences press for expression. Avoidance of these issues cannot make them go away. Therapists cannot magically erase the anxiety and pain related to such issues, but can provide tools that may help reduce the intensity of the work. If I sense that I am resisting dealing with particular issues, I should discuss my resistance with my therapist and try to overcome it.

I agree to inform my therapist of any plans of self-harm, suicide, homicide, or destruction of property that could endanger others and I agree to honor contracts with my therapist in these matters.

I understand that misunderstandings can occur between myself and my therapist. I also understand that I may develop troublesome feelings toward my therapist, such as fear or anger. Any of these problems can interfere with treatment. Therefore, if these problems occur, I agree to discuss them openly with my therapist in order to attempt to resolve any problems or to plan to terminate therapy.

Initial here if this section has been read and understood_____

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Consent for Agreement and agree to the above terms. If you have any complaints regarding the practice of your psychotherapist, you may contact the Board of Behavioral Sciences at 1625 N. Market Blvd., Suite S-200 Sacramento, CA 95834.

Client's Printed Name	Date	Signature
Parent's Printed Name	Date	Signature
Meg Elam, LCSW	Date	Signature

Consent for Treatment of a Minor

I, the undersigned parent/guardian of (patient) _____, authorize and request that Meg Elam, LCSW, to carry out psychological assessment, diagnostic procedures, and/or treatment which now or during the course of his/her care as a patient are advisable.

I understand that if the minor is an adolescent, the content of his/her private session will also remain confidential. However, general directions the minor is taking in therapy and how I may be able to maximize his/her positive growth will be provided. Occasionally, I may be asked to participate in a session with the minor to assist him/her to communicate his/her progress and goals.

I also understand that I will be informed of any safety concerns to the minor. I understand this authorization may be revoked, in writing, at any time. If not previously revoked, this authorization shall remain effective one year from the date of the signature below.

Client's Printed Name	Date	Signature
Parent's Printed Name	Date	Signature
Meg Elam, LCSW	Date	Signature