Informed Consent

The sample which follows is one example of what might be included in a disclosure statement and/or agreement for services. The therapist may adopt some or all of it to meet his or her particular needs.

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information About Your Therapist

At an appropriate time, your therapist will discuss his/her professional background with you and provide you with information regarding his/her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

Note: The therapist should indicate his/her licensure status before the patient completes this form.

Your therapist is a:

- ☐ Licensed Marriage and Family Therapist
- ☐ Marriage and Family Therapist Registered Intern*
- ☐ Licensed Clinical Social Worker
- ☐ Associate Clinical Social Worker*
- ☐ Licensed Psychologist
- ☐ Psychological Assistant*
- ☐ Licensed Professional Clinical Counselor
- ☐ Professional Clinical Counselor Intern
- ☐ Marriage and Family Therapist Trainee*
- ☐ Registered Psychologist*

* If your therapist is a Marriage and Family Therapist Registered Intern, Marriage and Family Therapist Trainee, Associate Clinical Social Worker, Psychological Assistant, Registered Psychologist or Professional Clinical Counselor Intern, his/her practice is conducted under the supervision of a licensed mental health professional. The clinical supervisor's name, license type and license number are listed below:

_____	_____	_____
Name of Clinical Supervisor (if applicable)	License Type	License Number

Information About This Practice (as applicable)
(Note: If the therapy practice uses a fictitious business name, the name and license designation of the business owners must be disclosed. Similarly, if the business is a professional corporation, the patient must be informed of that fact.)

The name of this practice is: _____

The individual therapist(s) who operate this practice is/are:

_____	_____	_____
Name of Therapist	License Type	License Number

(Required disclosures for professional corporations.)

_____ This practice is a Licensed Marriage and Family Therapist Corporation.
_____ This practice is a Licensed Clinical Social Worker Corporation.

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_____ This practice is a Psychological Corporation.

(Note: All therapists are required to disclose information about their fees in advance.)

Fees and Insurance

The fee for service is $__per individual therapy session.

The fee for service is $__per conjoint (marital /family) therapy session.

The fee for service is $__per group therapy session.

Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes in length

Fees are payable at the time that services are rendered. Please ask your therapist if you wish to discuss a written agreement that specifies an alternative payment procedure.

Please inform your therapist if you wish to utilize health insurance to pay for services. If your therapist/provider is a contracted provider for your insurance company, your therapist/provider will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although your therapist/provider is happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with your therapist.

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

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. (In addition, your therapist will not disclose information communicated privately to him or her by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child, dependent adult or elder abuse. Therapists may also 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.

(Alternate version below for therapists who utilize a "No Secrets" Policy)

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.

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are

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urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hours in advance of your appointment. If you do not provide your therapist with at least 24 hours' notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

You are welcome to phone your therapist in between sessions. However, as a general rule, it is our belief that important issues are better addressed within regularly scheduled sessions.

You may leave a message for your therapist at any time on his/her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non urgent phone calls are returned during the therapist's normal workdays within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

Please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call.

You should be aware that your therapist is generally available to return phone calls within approximately _____hours.

Your therapist is not able to return phone calls after_____.

Your therapist is not available to return phone calls on _____.

If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail message.

In the event of a medical or psychiatric emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: ( ) _____
Youth Shelter: ( ) _____
Domestic Violence Help: ( ) _____
Hospital: ( ) _____
Other: ( ) _____

Therapist Communications

Your therapist may need to communicate with you by telephone or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

- ☐ My therapist may call me on my home phone. My home phone number is: ( ) _____
- ☐ My therapist may call me on my cell phone. My cell phone number is: ( ) _____
- ☐ My therapist may send a text message to my cell phone. My cell phone number is: ( ) _____
- ☐ My therapist may call me at work. My work phone number is: ( ) _____
- ☐ My therapist may communicate with me by e-mail. My e-mail address is: _____
- ☐ My therapist may send a fax to me. My fax number is: ( ) _____

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☐ My therapist may send mail to me at my home address.
☐ My therapist may send mail to me at my work address.

(Disclosure statement regarding policies and procedures for using e-mail or text message can help patients understand and acknowledge certain limitations and risks that accompany electronic communications.)

Sensitive, clinical information is to be discussed over the phone or in-person as deemed appropriate by the therapist. For appropriate e-mail or text communication therapist will respond to your e-mail or text within 24 hours. Potential risks of using electronic communication may include, but are not limited to; inadvertent sending of an e-mail or text containing confidential information to the wrong recipient, theft or loss of the computer, laptop or mobile device storing confidential information, and interception by an unauthorized third party through an unsecured network. E-mail messages may contain viruses or other defects and it is your responsibility to ensure that it is virus-free. In addition, e-mail or text communication may become part of the clinical record. You may be charged for time the therapist spends reading and responding e-mail or text messages.

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 to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Your therapist will work with you to develop an effective treatment plan. Over the course of therapy, your therapist will attempt to evaluate whether the therapy provided is beneficial to you. Your feedback and input is an important part of this process. It is the goal of your therapist to assist you in effectively addressing your problems and concerns. However, 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.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your therapist to address any questions or concerns that you have about this information before you sign.

_____
Name of Patient

_____
Signature

_____
Date

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