



CONSENT TO CONSULTATION / TREATMENT

The following is an agreement to enter into a CONSULTATION/TREATMENT PROCESS. The purpose of this process is:

- 1) To affirm the fit between Prepare to Change and you as the client; and
- 2) To determine an appropriate therapist for you.

During the consultation process both you and your therapist can mutually agree to decide to move into psychotherapy treatment together.

Prepare to Change is a counseling center. As such, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of your personal health information for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of your first session.

CONSULTATION PROCESS: Your first sessions are a consultation which includes:

- Completing necessary paperwork;
- Meeting with a therapist; and
- Possibly taking a Personality Assessment Inventory (PAI).

If it appears that we can provide you with services helpful to your concerns, you will be assigned a therapist. However, it is sometimes necessary to refer you to another clinician. If this occurs, your file will automatically be transferred to your regular ongoing therapist with your written permission.

APPOINTMENTS: Your appointment time is reserved for you. It is your responsibility to notify your therapist or office administrator at least 48 hours in advance if you are unable to attend. **Cancellations of appointments less than 48 hours in advance and “no shows” are subject to the full fee for the appointment time.**

LIMITS ON CONFIDENTIALITY: There are some situations in which a therapist is legally obligated to take actions that the therapist believes are necessary to attempt to protect client or others from harm, and the therapist may be required to reveal limited information about a client’s treatment.

CHILD ABUSE: If a therapist has knowledge of or reasonably suspects a child under 18 has been the victim of child abuse or neglect, the law requires that the therapist file a report with the appropriate government agency. This can include when a therapist reasonably suspects that mental suffering has been inflicted upon a child or that his/her emotional wellbeing is endangered in any other way. It can also include some sexual activity i.e. oral sex among minors under certain conditions. If you have any questions please clarify this with your therapist. Once such a report is filed, the therapist may be required to provide additional information.

DANGER TO SELF: If a therapist has **reasonable cause to believe that the client is in such mental or emotional condition as to be dangerous to oneself**, the therapist may be obligated to take protective action, including seeking hospitalization or contacting family members or others who can help provide protection.

THREAT OF VIOLENCE TO OTHERS: If a client communicates **a serious threat of physical violence against an identifiable victim**, the therapist must take protective actions, including notifying the potential victim and contacting the police. The therapist may also seek hospitalization of the client or contact others who can assist in protecting the victim.

ELDER/DEPENDENT ADULT ABUSE: If a therapist observes or has knowledge of an incident that **reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult**, or if an elder or dependent adult credibly reports that he/she has experienced behavior including an act or omission constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, the law requires that the therapist report to the appropriate government agency. Once such a report is filed, the therapist may be required to provide additional information. **If such a situation arises, your therapist will limit disclosures to what is necessary.**

PRIVACY: The law protects the privacy of all communications between a client and a therapist. In most situations, your therapist can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by state law and/or HIPAA. **However, there are some situations where your therapist is permitted or required to disclose information without either your consent or authorization:**

CONSULTATION: Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, he/she will make every effort to avoid revealing the identity of clients. The other professionals are also legally bound to keep the information confidential. Your therapist may not discuss these consultations with you unless he/she feels that it is important to your work together. All consultations are noted in your Clinical Record.

ADMINISTRATIVE STAFF: Your therapist may need to share protected information with administrative staff for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All our mental health professionals are bound by the same rules of confidentiality, and all staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

COLLECTION: Disclosures required to collect overdue fees are discussed elsewhere in this Agreement. If you do not pay your fee, we are legally permitted to contact a collection agency.

COURT PROCEEDINGS: If you are involved in a court proceedings and a request is made for information about the professional services provided to you, such information is protected by therapist-patient privilege law, and will be provided only with your (or your legally-appointed representative's) written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where that party has given you proper notice (when required) and has stated valid legal grounds for obtaining PHI and your therapist does not have grounds for objecting under state law (or you have instructed him or her not to object). If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

GOVERNMENT AGENCIES: If a government agency is requesting the information for health oversight activities pursuant to their legal authority, your therapist may be required to provide it for them.

LAWSUITS: If a client files a complaint or lawsuit against his/her therapist, relevant information may be disclosed regarding that client, without client consent in order for the therapist to defend themselves.

WORKER'S COMPENSATION: If a client files a worker's compensation claim, the therapist must, upon appropriate request, disclose information relevant to the claimant's condition to the worker's compensation insurer.

NON-EMANCIPATED MINOR CLIENTS under 18 years of age can consent to psychological services subject to the involvement of their parents or guardian. The following statutes may be applicable in this situation:

- Therapist must determine whether or not parental involvement will be inappropriate for the minor.
- Minors over 12 years of age may participate intelligently in therapy services when the minor client either would present a danger of serious physical or mental harm to him/herself or others, or is the alleged victim of incest or child abuse.
- Minors over 12 years of age may independently consent to alcohol and drug treatment.

- Parents or guardians of clients under 18 years of age who are not emancipated may be allowed to examine their child's treatment records unless the therapist determines that access would have a detrimental effect on the professional relationship with the client, or to his/her physical safety or psychological well-being.
- Minors over 12 years of age will be required to sign a consent to treatment and the therapist may provide parents or guardians with only general information about the progress of the treatment, a summary of treatment, and the client's attendance at scheduled sessions. Any other communication will require the minor's authorization, unless the therapist believes that the child is in danger or is a danger to someone else, in which case, the therapist will notify the parents or guardians of such concerns. Before giving parents any information, the therapist will discuss the matter with the minor, if possible, and try to handle any of the therapist's objectives.

ONLY COMPLETE IF APPLICABLE:

If the following information is completed, please note that your therapist is PRE-LICENSED:

I understand that my counselor is an: **MFT Trainee, MFT Intern, Doctoral Student, or Psychological Assistant** and, as such, is not licensed, but is functioning under the supervision of their supervisor. I acknowledge that my counseling will be reviewed and supervised weekly by a licensed supervisor. I understand that the primary supervisor has full access to the treatment records in order to perform supervision responsibilities.

Therapist Initials _____ **Supervisor Initials** _____ **Client Initials** _____

TERMINATION OF THERAPY: Your therapist will provide counsel for you regarding termination, but you must make the ultimate decision about continuing care. It is to the client's advantage that a decision to end therapy will be discussed candidly and thoroughly with the therapist in advance of leaving.

PAYMENT & FEES: You are expected to pay for services at the time they are rendered unless other arrangements have been made. Services are rendered and charged to the client, not to the insurance company. Your therapist will provide you with a SuperBill to submit to your insurance company for reimbursement. You may also incur charges for phone calls lasting more than 15 minutes, letters and testing fees. There is a \$20.00 charge for returned checks.

I, the client, agree to be responsible for the payment of \$ _____ per session (50 minutes) which is payable at the time of the session. I understand that I am responsible for payment, even though I may be reimbursed by my insurance company.

Your signature below indicates that you have read this Agreement, agree to its terms, and acknowledge that you have received the HIPAA notice form described above. Please feel free to discuss any concerns you may have with your therapist as they arise. This form is a HIPAA document and complies with both state and federal requirements.

Client Name (please print): _____

Authorized Signature for Client

Date