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# CONSENT FOR TREATMENT

**Welcome**

Welcome, and thank you for choosing my practice. This document contains important information about my professional services and business policies. Please read it carefully and we will discuss any questions you might have. When you sign this document, it will represent an agreement between us.

I believe in the healing potential of counseling and psychotherapy to improve an individual's mental health, general well-being, and quality of life. It is my commitment to provide superior quality counseling and psychotherapy that supports you in living fully.

***COUNSELING AND PSYCHOTHERAPY SERVICES***

Counseling and psychotherapy are transformational processes which will vary with each individual. The focus is on the experiences, thoughts, feelings, behaviors, and perceptions of each client.

In therapy, I use a variety of therapeutic techniques, which will be explained to you in depth, and to which you always have the right to refuse. These techniques are likely to include, but are not limited to, psychodynamic therapy, Dialectical Behaviorial Therapy, Mindfulness, Eye Movement Desensitization Reprocessing (EMDR), meditation and relaxation, suggested reading, and journaling.

There are many possible benefits from counseling and psychotherapy that may include:

- Increased awareness and understanding of your feelings, emotions, and your deepest truth.
- Learning to communicate your truth so that you feel heard and understood, and so that you hear and understand others
- Learning new choices to address old problems and behaviors
- Developing healthy personal boundaries
- Understanding how your past experiences affect your current life and how to live in the present
- Increased compassion for yourself and others
- Resolving the issues and/or concerns that led you to seek counseling/psychotherapy
- Increased ability to cope with stress and work through difficulties

The goal of therapy is to heighten each client's mental health and quality of life. However, there are possible responses to the therapeutic process that can feel uncomfortable, but that usually resolve during therapy. Some of these responses are:

- Increased awareness and experience of feelings that have not previously had a "name," like sadness, anger, shame, and guilt, which can be emotionally painful
- Increased feelings of frustration and loneliness
- Additional issues that might arise with increased awareness
- Feeling worse before feeling better as you become aware of your feelings and break through numbness
- Possible disruptions in the relationships you currently have as you decide to live your life differently from the past
- Having no experience of change



Initials: Client: _____ Parent/Guardian: _____ Therapist: _____

If you have concerns about any of the above possibilities, please discuss them with me.

While there are no guarantees as to the results of counseling/psychotherapy, the feeling of having a successful therapy experience depends a lot on your intention, follow-thorough, and willingness to engage in the therapy process.

**CONFIDENTIALITY**

The confidentiality of the therapy you experience with me is one of my utmost priorities.

This confidentiality is guaranteed to you in several ways, and there are also exceptions.

The issues, feelings, experiences, behaviors, etc., that you talk about in therapy are kept confidential per State and Federal law. A confidential record of your therapy is kept in a secure place, as is required by the Arizona Licensing Board.

Also, you will sign an **Authorization for the Release and Receipt of Confidential Information.** This form clearly designates the individuals whom you agree to have knowledge of your therapy process. You have the right to change or completely rescind this authorization at any time without any consequences to your therapy process. If there are any potential ramifications of withdrawing the authorization for your therapist to share your therapy information, these will be explained to you. This authorization will remain in effect for a year at a time, unless otherwise indicated by you.

The exceptions to your confidentiality, as outlined in State and Federal Law are:

- In most legal proceedings, you have the right to prevent your therapist from providing any information about your therapy. However, in some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your therapist's testimony if s/he determines that the issues demand it.
- There are some situations in which I am legally obligated to take action to protect vulnerable individuals from harm, even if I have to reveal some information about your therapy. These situations include child abuse, elder abuse, or abuse of a disabled person.
- If I believe that a client is threatening serious bodily harm to another person, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- If I believe that you are in imminent danger of harming yourself, I am obligated to take protective actions that could include hospitalization and/or contacting family members or others who can help provide you protection.
- If you are under 18 years of age, the law gives your parents/guardians the right to examine your therapy records. I request an agreement from parents/guardians that the counseling sessions remain confidential. If you are in danger of hurting yourself or someone else, I will notify your parents/guardians.
- If you participate in a therapeutic group that I facilitate, it is important that you understand there is no guarantee that all group members will maintain confidentiality. Each group member will sign the same agreement for confidentiality, but that does not guarantee that someone in your group will not discuss your issues without you present. If you believe that this is happening, please let me know so that the appropriate steps can be taken.
- If collection action is taken for payments due (see explanation below).
- If otherwise required by law.

**It is very important for you to know** that I will discuss these situations with you, if at all possible, before taking any action. Your input is extremely important in any of these situations.

**Also,** it is extremely important for you to understand the distinction between talking about self-destructive thoughts, feelings and some behaviors, and being in imminent danger. It is an essential part of your therapy that you feel free to discuss any thoughts or feelings about self-destructive behaviors. That is part of the therapy process. It is only in cases where you are not able to keep yourself safe that we are obligated to take action.

If you choose to communicate with me by e-mail, please be advised that e-mail is **not** confidential. All e-mails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at

these logs, they are, in theory, available to be read by the internet service providers.

**Please** discuss any concerns about confidentiality with me.



Initials: Client: _____ Parent/Guardian: _____ Therapist: _____

***TREATMENT RECORDS***

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

I will be happy to send your records to a mental health professional of your choice. All patients will be charged an appropriate fee (25 cents per page and $30 per hour clerical fee) for any time spent in preparing information requests. If I am incapacitated, I will refer you to another therapist to continue your therapy. If you would like a copy of your records, please send me a signed dated letter stating that you are requesting them to be released to you. Please keep a copy of all this information for your records.

Clients will be expected to maintain the confidentiality of anyone seen or met at the counseling office. Your records will be kept for 7 years from the date of your last consultation and then will be shredded or burned.

In case of my demise or retirement, records will be stored/maintained through Accurate Medical Billing with whom I have a professional confidentiality agreement, for the remaining years. Their phone number is (602) 571-0233
.

***THE RELATIONSHIP BETWEEN CLIENT AND THERAPIST***

The relationship between client and therapist is a very important part of the therapy process and often takes several sessions to develop. You are encouraged to ask questions about anything that happens during your therapy experience. I am willing to discuss the process, the interactions we have, any therapeutic techniques or modalities that are used, and anything else that you have a question about.

Not all client/therapist relationships turn out as well as expected. If you decide that our therapy relationship is not a good match for you, please discuss this with me, as many issues can be resolved in this manner. However, if I am not the right therapist for you, I will gladly give you referrals for another therapist.

***TREATMENT PLAN***

The first few sessions will involve an informal evaluation of your needs and reasons for coming to therapy at this time in your life. After these first few sessions, we will develop a **Treatment Plan** that outlines the therapeutic work we will do, how we will do it, and the goals for this work. We will sign the **Treatment Plan**, and you will receive a signed copy. The **Treatment Plan** will be reviewed together with your therapist on an annual basis, and more frequently if needed or wanted.

You are an integral part of developing this **Treatment Plan**, and have the right to review and/or revise it at any point in the therapy process. You also have the right to refuse any recommended therapy modalities, and to have the possible consequences (if any) of the refusal explained to you.

***COUNSELING/PSYCHOTHERAPY SESSIONS***

Individual sessions are 45-53 minutes. Group sessions are typically 60-90 minutes.You and your therapist can discuss any changes from these time frames appropriate for your individual situation. The frequency of your sessions and the length of therapy is also up to you and your therapist, based on your clinical needs and what your insurance company allows.



Initials: Client: _____ Parent/Guardian: _____ Therapist: _____

**Fees and Cancellation policy:**

Cash, credit or debit card, Venmo, Paypal and checks are accepted. Please make checks out to Susan Hayes Counseling.

The fees for self pay sessions are:

$___95_____ for initial session $_____ INSURANCE CO-PAY

$___85____ per 60 minute individual sessions

$___40_____ for group sessions

At this time, I accept United, Cigna, Aetna, Blue Cross/Blue Shield, HealthNet, Magellan, Humana and Tricare.

PLEASE NOTE: As a contracted provider for these insurance companies, I am not authorized to reduce fees. If you miss a session and owe a cancellation fee, **the full allowable amount** for the session, as determined by your insurance company, will be charged. **Not the copay or coinsurance amount.**

Payment for counseling/psychotherapy sessions is due at the time of the session, unless otherwise arranged. I am happy to bill your insurance company for your therapy. **The copay or coinsurance must be paid at the time of service.** Your therapist will check benefits for your insurance plan, provided enough time is allowed prior to your session to do so. If your deductible has not been met, then you will be responsible for the full allowable amount determined by your insurance company. I also ask that you provide your insurance information to me via email so that my billing associate can determine eligibility and benefits.

**If you miss a session without notifying me or cancel with less than 48 hours notice, you will be charged the full allowable amount for the session unless you reschedule and attend during the same calendar week (MONDAY-SUNDAY).**

If you provide 48 hours or more advanced notice of an absence, you will not be charged for that session. There will be a returned check fee equal to that charged by your therapist's bank.

There is also a charge for other professional services, including report writing, telephone conversations lasting longer than 15 minutes per week, answering e-mails, attendance at meetings with other professionals that you have requested, the preparation of records or treatment summaries, and the time spent performing any other services you request of your therapist. These services will be billed at $125 per hour. If you become involved in legal proceedings that require your therapist's time, those hours will be billed at $250 per hour, including preparation and travel time.

If your account has not been paid for more than 30 days and arrangements for payment have not been made, your therapist has the option of using legal means to secure payment for services. If such legal action is necessary, the costs will be included in the claim. In most collection situations, the only information released is your name, contact information, the nature of the services, and the amount due.

**Your signature on this document constitutes an agreement to the above terms.**

***TERMINATION BY CLIENT***

The Consent for Treatment can be revoked by you at any time, and you have the right to leave therapy at any time.

Termination is an important part of the therapy process, regardless of how many sessions you have had. Please allow yourself at least one session for closure if you are terminating before you and your therapist have discussed the ending of therapy.

***TERMINATION BY THERAPIST***

Your therapist may consider terminating your therapy and suggest another professional if you are not progressing in therapy, or if the training and skills of the therapist is not what is needed for your clinical treatment. If these situations arise, we will discuss the possible responses.

If you, as a client, physically or verbally threaten to do harm to your therapist, or any family members of the therapist, another client, and/or to any aspect of the offices, I reserve the right to unilaterally terminate you from

therapy and contact the police if deemed necessary. If this situation should arise, you will be given referrals to other sources of care.

Your signature below indicates that you have read the Consent for Treatment, have had the contents explained to you if needed, have had time to ask questions, consider it, and understand it.

**Your signature here indicates:**

- That you understand the limits of Confidentiality that are required by law
- That you agree to the fee and payment for sessions
- That you understand your rights as a client, and
- That you understand that your Consent for Treatment and Authorization for the Release and Receipt of Confidential Information can be revoked by you at any time.

_____ _____
Client Name Date

_____
Client Signature

_____ _____
Parent/Guardian Name Date

_____
Parent/Guardian Signature

_____ _____
Therapist Signature Date



Initials: Client: _____ Parent/Guardian: _____ Therapist: _____