Informed Consent for Psychotherapy

General information
The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This Consent will provide a clear framework for our work together. Feel free to discuss any of this with the therapist.

The Therapeutic Process
You have taken a very important step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at time, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstances will change. The therapist will support you and do his/her very best to understand you and repeating patterns, as well as to help you clarify what it is you want for yourself.

Confidentiality
The session content and all relevant materials to treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/ persons, subject to the professional judgment of the therapist. Limitations of such client held privilege of confidentiality exist as identified below.

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a way where there is a substantial risk of incurring serious bodily harm.
2. If a client threatens bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years old.
4. Suspicions as states above in the case of an elderly person or vulnerable adult who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and #4.
6. If a court of law issues a legitimate court order, subject to HIPAA and Michigan law, and as determined in the sole professional judgment of the therapist.

Occasionally therapist may need to consult with other professionals in their area of expertise in order to provide the best treatment for me. Information about me may be shared in this context without using my name or identifying information.

Using Insurance for Services
I understand that in choosing to use my insurance for services I give Laura Jennings, LMSW PLLC permission to bill my insurance company for services rendered to me or my dependents and to release any information such as diagnosis, treatment plans, and Protected Health Information as necessary to obtain payment for services, and as allowed by HIPAA. I agree to disclose all relevant and current insurance information both completely and accurately including any changes to my insurance coverage. I understand that it is my responsibility to understand my insurance benefits, including limitations and/or exclusions, deductibles, co-pays, yearly maximums, and authorizations for treatment as applicable. Staff may try to help me navigate my insurance benefits, but ultimately, I am responsible for understanding my benefits.

Current Fee Schedule:
Intake appointment $180 45 minute session $150
60 minute session (extended session) $180 Group Therapy $50
Couples/Marriage Therapy $150 for 45 minute session, $200 for 90 minutes

Paperwork completion $25/document
External Communication and Extended Coordination $40/15 minutes IEP, School, or other external appointments $180/hour

I understand that out of pocket expenses that are not covered by my insurance company are my responsibility to pay and fees for services including copays are to be paid at the time of services. If my insurance company does not cover any fees for the services my dependent (s) or I have received, I accept full responsibility for these costs. If maximum insurance benefits have been reached, I will be fully responsible for any fees for services subsequently rendered to my dependent (s) or myself. I understand that many insurance companies will not and do not cover two mental health appointments on the same day and that I will be charged directly for one of the two appointments if this occurs.

- If I am late to an appointment by more than 10 minutes, I am aware that appointment may be on a cash-pay basis and I am liable for all charges at the time of the appointment.
- If I do not show to an appointment or cancel within 24 hours of the appointment, I am aware that I will be charged the fee for the appointment.
- If a diagnostic evaluation or treatment is terminated by choice or because of violation of client/ therapist agreement, I agree to pay all outstanding fees at time of termination.
- I understand that telephone consultations over 10 minutes may be subject to a charge, which my insurance will not always cover, in which case I will be financially responsible for the consultation. I agree to allow Laura Jennings LMSW PLLC to bill insurance for phone sessions, if covered.
- I understand that I will be made aware of any potential fees for any additional services requested and will have the opportunity to consent prior to receiving these services.

All services not covered by insurance are due and must be paid at the time of the appointment.

I understand that unpaid balances over $200 and/or 90 days old may automatically be transferred to a collection agency unless formal written payment arrangements have been made with Laura Jennings, LMSW PLLC. I understand that defaulting on any payment arrangement will lead to my account going immediately back into a collection status. I understand that treatment could be suspended for nonpayment and referrals will be provided.

Email Communications: By providing my therapist with my email, I acknowledge that my email address is personal to me and I authorize the therapist to communicate with me via email. I acknowledge that communications the therapist or his/her employees, contractors and staff via email are not secure, encrypted or confidential methods of communication. As such, I expressly waive the therapist's and Laura Jennings, LMSW, PLLC's obligation to guarantee security and confidentiality with respect to email correspondence. I acknowledge that all such communications may become a part of my medical record. I agree that email is not an appropriate means of communication regarding emergency or other time-sensitive issues or for communications regarding sensitive information. If I do not receive a timely response from the therapist to an email message I send, I agree to use another means of communication to contact my therapist. Neither my therapist, Laura Jennings, LMSW, PLLC nor its employees, contractors or staff will be liable to me for any loss, cost, injury, or expense caused by, or resulting from, a delay in responding to me, technical failures, interception of emails by a third party, or my failure to comply with the above guidelines regarding email communications.

Emergency Contact Person: My signature below evidences my agreement that if I have designated an emergency contact person, I consent and agree that such emergency contact person is involved in my care and that the therapist and Laura Jennings, LMSW, PLLC, its employees, contractors and providers may communicate with my designated emergency contact person to discuss my care, treatment and payments in compliance with applicable laws. My signature below further evidences that I am aware and agree that my decision to designate an emergency contact person is optional and that treatment will not be withheld by or conditioned upon my designation of an emergency contact person. My signature below evidences I acknowledge that regardless of whether I choose to designate an emergency contact person, my therapist and Laura Jennings, LMSW, PLLC and its employees, contractors and providers may make certain disclosures pertaining to my information, care, treatment and payment if such disclosures are permitted or required by applicable laws. I understand that I may change or revoke the emergency contact person that I designate (if any) in writing and that my revocation will not be effective for actions already taken by the therapist or that are in progress and will only be prospectively effective.

Contact Outside of *Therapy-* *If* we see each other accidentally outside of the therapy office, I understand that you will not acknowledge me unless I acknowledge you first. My right to privacy and confidentiality is of the

upmost importance to the therapist and does not wish to jeopardize my privacy. However, if I acknowledge you first, the therapist may be more than happy to speak briefly with me, but he/she feels it appropriate not to engage in any lengthy discussions in public or outside the therapy office.

My signature acknowledges that I have read, understand the Consent to Treatment, and that I agree to abide by the policies and procedures as outlined above, and that I have received copies of the Notice of Privacy Practices.

Name:_____Signature:_____Date: _____