



Informed Consent for Therapy Services

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.

THERAPY 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.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration. The time scheduled for your appointment is assigned to you. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours-notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount of \$40 [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. 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.

PROFESSIONAL FEES

The standard fee for the initial intake is \$120.00 and each subsequent session is \$80.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by credit card, check or cash. 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 15 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. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE

Please inform me if you wish to utilize health insurance to pay for services. I will discuss the procedures for billing your insurance. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. 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, which then become part of your medical record. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. You are responsible for obtaining prior authorization for treatment from your insurance carrier. Please discuss any questions or concerns that you may have about this with me.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. 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.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, call 911. I will make every attempt to inform you in advance of planned absences.

E-MAIL AND PHONE COMMUNICATION

Some patients prefer to communicate about appointment times or other administrative issues via e-mail or text message. E-mail and text messages transmitted through regular services are not encrypted. This means that a third party may be able to access information in an e-mail or text and read it, since it is transmitted over the Internet. In addition once the e-mail or text is received by you, someone may be able to access your e-mail account or text messages and read it. This may include your employer if you use a work-related e-mail address or work supplied cell phone. E-mail and text messages should be considered to be more similar to a "post-card" than to a sealed letter, and for that reason I discourage sending any clinical or other sensitive information via e-mail or text.

Please initial the options that meet your needs. You can change this at any time by communicating to me in writing.

I do not wish to receive any treatment-related information via e-mail.

I do not wish to receive any treatment-related information via text message.

I understand the risks of unencrypted e-mail, and do hereby give permission for Laura Woodruff to contact me or to reply to me via unencrypted e-mail. Please provide preferred e-mail address _____

I understand the risks of text messages, and do hereby give permission for Laura Woodruff to contact me or to reply to me via text message. Please provide preferred cell phone number for text _____

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment.

CONSENT TO THERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Signature of Client

Signature of Client or Guardian (If Client is Under 18)

Printed Name of Client

Printed Name of Client or Guardian

Date

Date