Jerry Andrews, LMFT, LISAC
Licensed Marriage, Family, Child Therapist
Licensed Independent Substance Abuse Counselor

INFORMED CONSENT FOR PSYCHOTHERAPY

This Informed Consent for Psychotherapy document contains important information regarding your rights as a client engaged in psychotherapy services. Please read it carefully. We will then discuss it and address any questions that you may have regarding the contents of this document.

Psychotherapy Services

People come into psychotherapy to address a wide variety of concerns and to reach individualized goals. These concerns can affect all areas of life. Sometimes working with a therapist regarding problems can be emotionally distressing and may lead to uncomfortable feelings such as sadness, anger, disappointment and guilt. Psychotherapy can also lead to resolution of these problems, improved relationships, or help people cope more effectively. ***There are no guarantees as to the outcome of psychotherapy and you may terminate services at any time.***

Methods of Treatment

The treatment approaches utilized will include Brief Solution-Focused Therapy, Family Systems Therapy, and Cognitive-Behavioral Therapy. These are therapies commonly used to treat the above concerns and have been researched and found to be effective.

Course of Treatment and Appointments

The first session we will meet together for an initial assessment. You may, if you wish, bring a friend, family member, or significant other person to this assessment with you. During this assessment we will discuss the history of the concerns that you bring to therapy, information about how these concerns affect your life including your thoughts, feelings and behaviors. At the end of our initial meeting, or the following session, we will discuss goals for therapy and create a treatment plan. ***The treatment plan will outline the anticipated course of treatment, including the number of visits. Again you may terminate therapy at any time.***

Appointments will usually be set for every two weeks (twice per month) but, depending on needs, may be more or less frequent. Sessions are typically 45-minute sessions and will be scheduled at a mutually agreeable time and day.

Policy on Termination of Services

Services may be terminated in two instances:

- When you have reached your goals or decide you no longer need this service or it appears that no further gains can be made at this time, or no future therapy appointments are scheduled, or if you would be harmed by continued care.
- If for some reason I feel threatened or endangered by yourself or someone close to you.

Cancellation Policy

If you are unable to attend a scheduled appointment, *you must provide 24 hours notice of cancellation. If you missed the scheduled appointment or cancel the appointment with less than 24 hours notice, a no-show fee or late cancel fee of $60 will be charged.* However, if the circumstances were out of your control, the fee may be waived.

Professional Fees and Payment

The hourly fee for my services is $125. In addition to psychotherapy appointments, other services may be provided and will be billed at the same rate. These other services, which you or others may request, may include such things as consultations with other providers, reports and records requests, and court proceedings, etc.

Payment of any insurance co-payment, and/or deductible is expected prior to therapy sessions. Your insurance benefits will be reviewed prior to your first service, however it is not uncommon to have the copay and/or deductible amount be established after your first session, you are still responsible for payment of this amount. Any verification of your insurance and billing of your insurance is a courtesy service that we offer. You should consult

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with your insurance plan administrator to evaluate any coverage you may have, the limits, and conditions of coverage. If you are covered by a contracted insurance, my office will attempt to seek reimbursement from your insurance carrier. **You remain responsible for the full fee due if your insurance company denies coverage or refuses to pay for therapy services rendered.**

In addition, we have no way of knowing if you are covered under an employer contracted Employee Assistance Program (EAP), nor are we able to seek authorization if you are entitled to EAP coverage under your specific employer plan. Most EAP's will not allow us to seek authorization for or verify that you have EAP coverage. EAP coverage and authorization remains your responsibility. **If during treatment you discover you were eligible for EAP coverage and did not provide this information to us, you remain responsible for any copays, deductibles, etc for those previous sessions.**

If you are experiencing financial hardship after therapy has been initiated, please consult with my office. Financial arrangements may be made and/or referrals to other low-cost providers for continued care. **If you are in a crisis you will not be denied care, regardless of your ability to pay for services.**

Emergency Contact Information

In a life-threatening emergency, please call 911.

If you are experiencing a mental health crisis, you may contact the county-wide crisis line at (602) 222-9444. During business hours (9:00 am – 5:00 pm) you may leave a message at the office and it will usually be returned within 48 hours. After hours you may page me at (602) 938-3323 Ext 14; again simply leave a message including your name and telephone number.

Client Records

Client treatment records are kept for a period of 7 years after termination of therapy or 3 years after the 18th birthday of the client, whichever is longer. You are entitled to a copy of your records, unless viewing the records would cause emotional harm to you. Upon signing a Release of Information form, records may be sent to other providers as you wish.

If you are a minor, your parents have access to your treatment records. Parents are usually asked to not request to look at the records as doing so may prevent you from sharing those things necessary for you to progress in treatment. A general statement of progress towards treatment goals will be provided to your parents on a regular basis.

Client's Rights and Responsibilities

Clients have the right to:

Be treated with dignity and respect.
Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
Have your treatment and your information kept confidential. Only where permitted by law may records be released without your permission. Please speak with provider for further clarification.
Easily access care in a timely fashion.
Know about your treatment choices. This is regardless of cost or coverage by your benefit plan.
Share in developing your plan of care.
Receive information in a language you can understand, and free of charge.
Receive a clear explanation of your condition and treatment options.
Receive information about the provider, services, and role in the treatment process.
Receive information about clinical guidelines used in providing care.
Ask your provider about their work history and training.

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Give input on the Client's Rights and Responsibilities.
Know about advocacy and community groups and prevention services.
Know your rights and responsibilities in the treatment process.
Request certain preferences in a provider.
Have provider decisions about care made on the basis of treatment needs.
Decline participation from therapy.

Clients have the responsibility to:
Treat those giving them care with dignity and respect.
Give provider information that they need. This is so provider can deliver quality care.
Ask questions about your care. This is to help understand your care.
Follow the treatment plan. The treatment plan is to be agreed upon by the client and provider.
Follow your medication plan, and let your PCP and/or Psychiatrist know of any significant changes in functioning.
Tell your provider and PCP about medication changes, including medications given to you by others.
Keep your appointments. Client should call provider's office as soon as they now they will need to cancel and/or reschedule a visit.
Let your provider know when the treatment plan is not working for you. Provide feedback about potential barriers to improved functioning.

Confidentiality
Privacy between a client and a psychotherapist is protected by law. Information may only be released with written permission except where there are concerns about danger to you or danger to others, if required by court orders, licensing requirements, or for your insurance provider.

If I believe that you may harm yourself or someone else, or if a child or dependent adult has been harmed, I must act to protect yourself and others. This may involve informing the police, reporting information to Child Protective Services or Adult Protective Services, seeking emergent hospitalization and/or requesting a court ordered evaluation for continued treatment.

Primary Care Physician (PCP) Communication Best Practice

Communication between multiple practitioners involved in a client's/patient's health care is essential to facilitating care coordination so that the treatment provided is of a high quality with an emphasis on safety. The nature of the (PCP) Primary Care Physician's role is serving as the central coordinator of the client/patient's entire medical care requires that specialists, such as those in behavioral health, initiate and maintain ongoing communication to provide significant healthcare information, with the client/patient's consent.
PCP communication from the behavioral health provider is one essential element of coordination of care. Some clinical situations or circumstances require frequent and comprehensive communication to ensure patient safety. Other situations, due to the nature of the treatment and lack of co-morbid medical conditions, don't require as frequent or in depth communication.
Improving the communication between behavioral health providers and Primary Care Physicians (PCP) is an opportunity to enhance the quality of patient care. This communication is particularly important when:

+ There is an emergency;
+ Medical co-morbidities and/or medication interactions are possible;
+ Clinical information is needed to aid in diagnosis or treatment;
+ Primary care support for a treatment plan would enhance client/patient compliance and/or treatment outcome;

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+ Primary care physicians have requested immediate feedback.

Optimally, those reports are to be sent to the member's primary care physician after:

+ The client/patient's initial evaluation or first visit;
+ Termination of care;
+ Significant change in the member's clinical status, diagnosis or treatment plan
+ Medications are initiated or significantly altered.

Authorization to Disclose Protected Health Information to Primary Care Physicians

Your option to share behavioral health information with your primary care physician or prescriber would require an authorization to disclose protected health information by completing the Release Of Information form and a signature requirement by the client/patient, or guardian. The completed form allows the behavioral health provider to inform the PCP that behavioral health treatment is occurring, and also provides information on how to contact the behavioral health provider if needed. If you would like me to release applicable mental health information to your PCP then please make that known at your initial session (A separate Release of Information form will need to be completed & signed).

Otherwise, it is assumed **No Need to release any information at this time to my PCP.**

INFORMED CONSENT FOR TELE-HEALTH THERAPY SERVICES

The use of tele-health services is an effective way to deliver psychotherapy services. There are special considerations to consider when engaging in this type of therapy.

Confidentiality – There are inherent confidentiality risks with electronic communication. The services provided are via a secure and HIPPA compliant platform. You should ensure that your location is private when engaging in this type of service. Confidentiality still applies for tele-psychotherapy services, and nobody will record the session without the permission of the other person(s).

Potential for technology failure – If there is a problem with the technology, alternate means of contact (i.e. telephone) will be attempted or the session might need to be rescheduled.

Emergency procedures - If for some reason the therapist is not available for the session due to an unforeseen emergency, the therapist will contact you at the next opportunity to reschedule. Alternatively, you can contact my office at 602-938-3323.

Verification of attendant – if the session is audio only, the therapist will confirm your identity with address and date of birth.

It is important to use a secure internet connection rather than public/free WIFI.

If you need to cancel or change your tele-appointment, please notify me in advance by email at JerryAndrews@GlendaleTherapyAssociates.com, or phone the office 602-938-3323 Press 0 for front office staff, Ext 14 for Jerry Andrews.

In the event of technical problems we can switch to use of the telephone.

Minors will require permission from a parent/legal guardian to participate in tele-health sessions.

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Acknowledgement of Informed Consent & Payment

Payment Coverage
I require credit/debit card information to be in your file, **if you refuse to provide this information, this may revoke your consent for treatment,** also if you are unable to provide this information you may discuss options with Jerry Andrews. In the event a balance is owed, a courtesy Statement will be mailed to you indicating the amount owed and the reason. If after 30 days payments have not been received then you are authorizing credit/debit card you provided on file to be charged. The following are some reasons for balance owed:

- Our session is cancelled later than the 24 – hour policy.
- Your appointment is missed without the 24 – hour cancellation.
- A payment is due, Ie copay, deductible, insurance denial, etc.

Your information will never be sold or given to a person, business or organization for any other purpose.

By signing below, you indicate that you have read, understand, hereby consent to treatment and agree to the policies as outlined above, hereby agree to the release of protected health information for the purposes of billing insurance, or payor, and agree to bring up any questions you have pertaining to this document with Jerry Andrews. By signing this document, you are agreeing to begin treatment.

Client/Patient: _____
Print Name / Signature Date

If client is under the age of 18, will also need:

Legal Guardian: _____
Print Name / Signature Date

For couples, will need:

Significant Other: _____
Print Name / Signature Date

For any additional participants:

Participant: _____
Print Name / Signature Date

Participant: _____
Print Name / Signature Date

Participant: _____
Print Name / Signature Date

Provider Signature _____
Jerry Andrews, LMFT, LISAC Date