

**INFORMED CONSENT FOR TREATMENT/EVALUATION
BY BEVERLY C. TAYLOR, MA, LMFT - MFC#41786 and/or FAMILY
COUNSELING & TRAUMA HEALING CENTER, INC.**

Following is information that is relevant to your decision to receive psychotherapeutic treatment/evaluation.

GENERAL INFORMATION: There might be alternative treatment approaches available for your condition. You are free to discuss those options with your therapist at any time. You may also seek consultation with another professional about possible treatment options.

Psychotherapy, while intended to heal, carries some risks. For example, at times while receiving treatment, a client might experience a temporary worsening of symptoms, due to focus on emotionally painful material. If you become concerned that your symptoms are worsening or that your treatment might be causing some negative side effect, please address your concerns with your therapist.

Many people find psychotherapy beneficial for a variety of problems. However, because many factors can influence treatment outcome, we are not able to guarantee that you will achieve all of your desired goals with treatment. If you have questions about the potential benefits of treatment for your situation, please discuss those questions with your therapist. If during the course of treatment, you become concerned that you are not benefiting from treatment, please discuss your concerns with your therapist.

You are free to discontinue treatment at any time. It is important that you understand that premature termination from therapy might result in failure to achieve desired treatment goals. You are encouraged to discuss the option of termination and its foreseeable implications given the specifics of your situation with your therapist, should you wish to consider it.

LIMITS OF CONFIDENTIALITY: Information you provide during treatment or evaluation is confidential and may not be disclosed without your permission, except under specific circumstances, as permitted or required by law.

Disclosure is **required by law** under the following circumstances:

1. where there is reasonable suspicion of child abuse
2. where there is reasonable suspicion of a dependent adult or elder abuse
3. if you communicate to the therapist that you seriously plan to harm another person physically

Disclosure may be permitted when there is reasonable suspicion that a client presents a danger of violence to himself or herself, or to the person or property of

another, and that disclosure of confidential information might prevent the threatened danger.

A court may require disclosure of confidential information in a legal proceeding where your condition or treatment is a relevant concern.

Finally, requests for treatment authorizations and submission of a bill to an insurance company or other third party payers for reimbursement often involve the disclosure of information about your condition, symptoms, treatment, or progress. Sometimes an insurance company will require copies of session notes or a summary, to authorize continuing treatment or process a claim for services rendered. If you request that we bill your insurance company or other third party payers, that request will constitute consent to release the information necessary to obtain treatment authorization and/or to process the claim. We will release only the information or materials that are appropriate and necessary for the purpose.

CONFIDENTIALITY IN GROUP/FAMILY/COUPLES TREATMENT:

Confidentiality is important to the therapeutic process because it provides the basis for trust and honesty. If you participate in a therapy modality that includes other clients, you are responsible for maintaining the confidentiality of what others disclose during the course of treatment. They have that same responsibility to you. Persons, who violate the confidentiality of another in group therapy, may be asked to discontinue the group treatment and may receive a recommendation for another treatment modality.

SECRETS POLICY: The therapists believe that some secrets, when held from a family, spouse, partner, and/or specific others, can be destructive to the relationships of the individuals involved, including the holder of the secret. When working with families, couples, or other groups, the therapist reserves the right, when asked to maintain a secret, to work toward its disclosure when disclosure has been determined by the therapist to be in the best interests of the parties involved.

CONSULTATION WITH OTHER PROFESSIONALS: At times, your therapist may deem it appropriate to consult briefly with another professional about your case. Brief consultations are ethically appropriate to ensure that you are being provided with the best possible treatment. If your therapist believes it is appropriate to consult with someone else regarding your case, she will not use your name or any uniquely identifying information unless you give permission to do so. If extensive consultation that would involve the disclosure of your name or other unique identifying information is required, your therapist will seek your written consent.

EMERGENCY CONTACT: Our office uses a 24-hour answering machine. Your therapist is at extension 208. In the event of a clinical emergency, it is suggested that you go to the nearest emergency room and/or call 911. Do not leave an emergency message on the voicemail, as it may be some time before that message is picked up by your therapist. If you are in need of 24-hour crisis information or hotline (including a 24-hour crisis counselor) you may call 211 and an operator will assist you and get you to the proper resource. If that call is unsuccessful (busy, etc) and you are in continued crisis, please contact 911 or go to the nearest emergency room. Your therapist will make every attempt to return your call in a timely fashion. Occasionally other obligations might prevent your therapist from returning your call immediately, again if this is the case, your emergency is life-threatening. Please call 911 immediately.

In the event of the unexpected death of long-term/permanent incapacitation of your therapist, you will be contacted by another clinician to arrange continued care. Beverly Taylor's clients will be contacted by Lisa Rakusin, LCSW or such other professional deemed to such role at the time of Beverly's death.

RECORD KEEPING AND ACCESS TO RECORDS: While your case is active, our records are maintained in an electronic secure data software package, and/or in paper format and stored in a locked file cabinet. Upon closure of the case, the records may be electronically archived or stored in a locked area. As a client, you have the right to request access to your records. Ethical standards require that we consider the impact that your viewing of the records might have on you before deciding how to respond to such a request. In some cases, the records or a summary may be released directly to you. In other cases, we might opt to release the records or a summary only to another licensed psychotherapist or physician.

FAILURE TO HONOR FINANCIAL AGREEMENT: Our financial policy is explained in detail on a separate form. You should be aware, however, that failure to honor your financial obligations with us may result in disclosure of your name and amount of money owed to a collection agency or credit reporting agency. **Sessions are 45-60 minutes in length and the cost is \$180.00 per individual session, \$220 for couple/family, payable at the beginning of each session. If you are using insurance for your sessions, you are responsible to pay the amount, in full, at the beginning of each session and you will be provided with a superbill to submit to your insurance company. Credit/Debit/Benefit cards may be used for sessions.**

FINANCIAL ARRANGEMENTS/THERAPEUTIC ISSUE: Your therapist understands that financial payment of sessions, etc. can also be a part of the therapeutic process. Therapy should not create further hardship, however, it is important that you place equal or greater value on your healing process as your therapist does. Your therapist understands that from time to time, you may forget

your checkbook, or need to miss a payment and catch up the following week, it is, however, imperative that you discuss this issue at the beginning of the session. **No accumulated copays or balances due will be accommodated, except in extreme cases, and only with prior written approval.**

SESSION TIMING: Therapeutic sessions are **45-60 minutes long**. Your therapist most likely will have a timer set denoting when there are ten minutes remaining in the session to allow for proper closure. Please understand that (except in very extreme cases) your session will not go beyond 60 minutes. **It is your therapist's responsibility to track the timing, not yours!** Your therapist attempts to keep it convenient for clients to be accommodated at the time scheduled for their appointment. If you determine you may need longer than the allotted 60-minute session, please arrange ahead of time with your therapist, and she will accommodate you for longer sessions, whenever possible.

GIFTS: At times, clients feel the need to thank their therapist on holidays or on special occasions. While an appreciation card or note is always accepted, ethically, I do not accept gifts of any kind.

CONSENT: I HAVE READ this Informed consent for Treatment/Evaluation. I have been provided with as an opportunity to ask any questions needed for clarification, received answers to all such questions, and with my signature affirm that I understand it and agree to treatment without any implied guarantee as to therapy results or outcome.

BILLING/SCHEDULING/OFFICE WORK: I hereby understand that office help for billing, scheduling, etc. will be used from time to time. These helpers sign a legal confidentiality waiver and are held by HIPPA privacy as well. They will not read the contents of the files but only my address for billing and telephone number for scheduling and scheduling changes.

I authorize and request that **Family Counseling & Therapeutic Healing Center, Inc. and/or Beverly Taylor, MA, LMFT**, her agents and/or employees, carry out psychotherapeutic evaluations, treatments, and/or diagnostic procedures which now or during the course of my care as a client are advisable. I understand that the purpose of such procedures will be explained to me and will be subject to my agreement.

Client Name Printed

Date

Client Signature