

Therapy Consent, Policies & Agreement

PART I: THERAPEUTIC PROCESS

**BENEFITS/OUTCOMES:** The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Progress will be assessed and feedback will be elicited to ensure the most effective therapeutic services are available. However, there can be no guarantees made regarding the ultimate outcome of therapy.

**EXPECTATIONS:** In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

**RISKS:** In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended.

**STRUCTURE OF THERAPY:**

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaborate to identify your therapeutic goals.
- **Intervention Phase** – This phase occurs anywhere from session two until discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for discharge/termination.

**LENGTH OF THERAPY:** Therapy sessions are typically weekly or biweekly for 45 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

**APPOINTMENTS AND CANCELLATIONS:** You are responsible for attending each appointment and agree to adhere to the following policy: *If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment within 48 hours of the scheduled appointment time. If you cancel or reschedule twice, we may re-evaluate your motivations for treatment at this time. Missed appointment/s maybe charged at the usual and customary rate.*

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

**FEES:** The fee for each 45 minute therapy session is \$225/\$200 or your insurance copay. Payment is due at the time of service. Acceptable forms of payment are: credit/debit cards. In the event that a scheduled appointment time is missed or cancelled less than 48 hours, please refer to the "Appointments and Cancellations" policy above.

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The clinician reserves the right to terminate the counseling relationship if more than two sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed via email.

**TRIAL, COURT ORDERED APPEARANCES, LITIGATION:** Rarely, but on occasion, a court will order a therapist to respond for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you, or your attorney, you will be charged a fee of \$925 to include travel time, court time, preparation of documents, etc.

**COPIES OF MEDICAL RECORDS:** Should you request a copy of your medical records, the cost is \$25 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 4 weeks to prepare medical records.

**PHONE CONTACTS AND EMERGENCIES:** Office hours vary per location. If you need to contact the clinician for any reason please call 650-889-0169, leave a voicemail, and a return call will be made, as soon as possible. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you, or someone else, is in danger of being harmed, dial 911, or go to the nearest hospital Emergency Room.

## **PART II: CONFIDENTIALITY:**

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *except* for the following limitations:

- **Child Abuse** - Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse** - Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you a written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of (ROI) form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/process notes". If therapy sessions involve more than one person, each person over the age of 18, MUST sign the release of information before information is released.

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- **Fee Disputes:** In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement") that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive.
- **Dual Relationships & Public:** Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media:** No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
- **Electronic Communication:** If you need to contact me outside of our sessions, please do so via phone or email.
  - Clients often use text or email as a convenient way to communicate in their personal lives. However, texting/email introduces unique challenges into the therapist-client relationship. Texting is not a substitute for sessions. **Texting is not confidential.** Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone.
  - **Do not use e-mail for emergencies.** In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **E-mail may not be confidential, unless otherwise identified.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.
- **Sessions Outside the Office:** This Provider does not participate in out-of-office sessions.

### PART III: HEALTH INSURANCE

**YOUR INSURANCE COMPANY** – By using insurance, I am required to give a mental health diagnosis that goes in your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

**IMPORTANT:** Some psychiatric diagnoses are not eligible for reimbursement. In the event of non-coverage or denial of payment, you will be responsible to pay for services provided. **Art of Wellness** reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.

**PRE-AUTHORIZATION & REDUCED CONFIDENTIALITY**—It is your responsibility to request the Authorization Number for therapy services from your Insurance to this Provider. It is also necessary for you to know your deductible amounts and co-pays. Otherwise, you will be responsible for paying for therapy services out-of-pocket. When the initial authorized sessions are complete, we may need to justify the need for continued services, or it may delay further treatment. If additional sessions are not authorized, it would lead to an end of the therapeutic relationship.

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**PART IV: CONSENT**

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Marcia Prinz, LCSW**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Marcia Prinz, LCSW** to provide counseling services that are considered necessary and advisable.

2. I authorize the release of treatment and diagnosis information (as described in Part III, above) necessary to process bills for services to my insurance company, and request payment of benefits to **Marcia Prinz, LCSW & Art of Wellness**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Marcia Prinz, LCSW & Art of Wellness** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren):** I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to **Marcia Prinz, LCSW** to provide treatment to my minor child(ren). If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Marcia Prinz, LCSW** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Printed Name of Minor Child	DOB	Date

It is necessary that Art of Wellness has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name	Relationship	Phone Number(s)
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By signing below I give my consent to the above 1,2 and 3 provisions. I also, allow Art of Wellness permission to contact my Emergency Contact Person, on my behalf, regarding an emergency.

Signature	Date
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*Please keep a copy for your records.*

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