CULTIVATING CHANGE
SPRINGFORTH COUNSELING

Informed Consent

Therapy is a cooperative venture with responsibility resting on both the therapist and the client. I agree to play an active role in this process. I understand that no promises have been made to me as it pertains to the results of my treatment. In order to enable that we work most effectively together, I ask that you carefully read the information below. If you have any questions, I will be happy to discuss them with you.

_____ (initial) **CONFIDENTIALITY:**

The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. An explanation of those rights is attached to this document.

Communications between client and therapist are confidential and will not be revealed unless required by law such as in situations of child abuse or threats of physical harm to self or others or subpoena of a court.

Your therapist will be discreet if it is necessary to contact you at home or at work. If you have a specific number that is best for contact please let your therapist know.

_____ (initial) **THERAPY FEES:**

The nominal fees for therapy sessions are as follows;

Intake therapy sessions are up to 60 minutes and cost $120.00. The fee for a 60-minute therapy session is 100.00, and a 45 to 50-minute therapy session is $90.00. Should a sliding scale and/or assistance be requested, it will be discussed prior to the intake session. The adjusted amount will be written below. There will be a $30.00 fee for all returned checks. Payments and Copays are due at the beginning of the session. I understand that if payment is not made your therapist may discontinue treatment.

ADJUSTED FEE FOR SERVICE: $_____ Client Initials: _____

Should your therapist be involved in a subpoena for legal proceedings on your behalf, an adjusted rate of $160 per hour will be charged, a minimal of 3 hours ($480.00) will be required for any preparation and attendance. A deposit of $500 will be required to secure attendance. A reimbursement of $20.00 will be given if time frame does not exceed 3 hours.

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I am aware that I may stop treatment at any time. I am also aware that I am required to pay for unpaid services I have already received. I also understand that if therapy is court ordered discontinuation of services will be reported to court.

_____ (initial) **INSURANCE:**
I participate in a variety of payment forms we will further discuss your preferred method of payment.

I am aware that an an agent of my insurance company or other third party payee may be given information about the type, cost, dates, and providers of any services or treatments I receive.

_____ (initial) **CANCELLATION OF APPOINTMENTS:**

Your appointment time is important to you, to your therapist, and to others who are in need of therapy. If you must cancel your appointment, please phone your therapist and leave a message on their voicemail at least 24 hours in advance of your scheduled appointment. ***A charge of $80.00 will be made for the time reserved when cancellations are received less than 24 hours in advance, except in case of illness or emergency. You are personally responsible for this charge and all future appointments may be cancelled until this fee is paid.***

_____ (initial) **TELEPHONE CALLS:**

Should you need to contact your therapist, you may leave a message on their provided phone number. All calls that are over 15 minutes in length, your therapist may ask if you would like to schedule a session or continue the telephone call for your nominal fee for a 50-minute session.

_____ (initial) **EMERGENCY PROCEDURES:**
If you have an emergency, you will need to contact either a hospital emergency room or the police depending on the situation. If you feel your life or someone else's is in danger call 911.

_____(Initial) **EMAIL AND CONFIDENTILITY AGGREMENT:**

When communication via email, it is important to remember that confidentiality is limited. By signing below, the client is saying that they have considered and understand the limitation of confidentiality and agree that the client is responsible for keeping their email account private to the extent that they desire for it to be private.

_____ (Initial) **TEXT MESSAGES AND CONFIDENTILITY AGGREMENT:**

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Therapists are discouraged from texting clients outside of normal business hours (9 am – 5 pm), and text messages are only to be used for scheduling reminders and questions. Any therapeutic processing should be reserved for sessions and/or phone consultation. By signing below, the client is agreeing that they have considered and understand the limits of confidentiality and agree that the client is responsible for keeping their text messages private to the extent that they desire them to be private.

_____ (Initial) **PROFESSIONAL BOUNDARIES:**

Therapists avoid any other relationships with clients outside of the therapeutic relationship, such as personal relationship, business relationship, or similar. Beyond confidentiality requirements, professional boundaries also play a role in respecting the privacy of Spring Forth Counseling clients outside of therapy. For example, if a client sees their therapist in a public setting, the therapist will not initiate communication with their client.

_____(Initial) **SOCIAL MEDIA:**

Therapists are prohibited from engaging in a personal virtual relationship with individuals with whom they have a current counseling relationship (e.g., through social and other media) – ACA Code of Ethics A.5.e.

_____(Initial) **COMPLAINTS:**

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform the therapist immediately and discuss the situation. If you do not feel the complaint has been resolved, we will assist with finding another provider who can provide adequate services.

I have read the above information and voluntarily request counseling services at Spring Forth Counseling and I agree with these terms and conditions*

Signature _____ Date_____

Printed Name _____ Relationship to Client_____

I, the therapist, have discussed the issues above with the client (and or his parent, guardian or other representative). By my observation is that the above party is fully competent to give an informed and willing consent.

Therapist Signature _____ Date_____

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referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPPA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPPA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Spring Forth Counseling is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

I have received a copy of the Spring Forth Counseling Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may at any time now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

Client Signature Date

_____ _____