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CONSENT FOR THERAPY SERVICES

Welcome.

The following policies and procedures are provided for our mutual understanding. If you have any questions or concerns about any of the following, please dis cuss with me prior to signing. Please initial in the space provided in each section and sign and date below.

Appointments and Cancellations

All therapy appointments can be made by phone or email. All sessions are 50 minutes. My fee for services is $175 per 50 minute session. Any sessions exceeding 50 minutes will be prorated. Telephone conferences exceeding 15 minutes are billable and will be prorated based on the fee of $175 per session. Initial___

Payment

For your convenience, I accept credit cards, cash or check. Please make checks payable to Miki Johnston. Payment is due at the end of each session. Cancellations can be made 24 hours in advance by phone or email. If you do not show up for your scheduled therapy appointment and the appointment was NOT canceled 24 hours prior, you will be required to pay the full cost of the session. Exceptions to this policy would include illness or emergencies. You are not obligated to any specific number of sessions. It is helpful, however, to give me 1 sessions' notice if you choose to terminate our work together so we can end the work effectively. Initial ___

Insurance

I am an out of network insurance provider. Upon request of the client, I can provide a monthly statement of services for those clients who wish to get reimbursed for therapy services through their insurance company. Depending on your health care provider, some fees for therapy may be covered or eligible for a percentage of reimbursement as out-of-network mental health services. If you opt to file with your insurance company, it is your responsibility to learn the type of mental health or behavioral health coverage you carry on your plan as well as the limitations of that coverage. Initial ___

Record-keeping

I will keep records of your appointments. Records entail brief details about each session, what interventions were used and the topics we discussed. If you prefer that I keep no records, you must give me a written request to this effect for your file and I will only note that you attended therapy in the record. Under the provisions of the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request (in writing) that I release your records to any other health care providers. I maintain your records in a secure location that cannot be accessed by anyone else. Initial ___

Confidentiality

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Initial ___

EXCEPTIONS:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Initial ___

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities. Initial ___

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. Initial ___

Insurance Providers

With the client's permission, insurance companies and other third -party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. Initial ___

Minor Clients

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of or would be upset by but that do not put you at risk of serious and immediate harm. However, if your risk -taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian (with your help if you are willing). Even if I have agreed to keep information confidential, I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. I will not contact your parent to provide them with information without telling you and encouraging/supporting you to tell them first. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you. Initial ___

Electronic Transmission

You are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information to you or about you. Whenever I transmit information electronically (for example, sending bills, transferring medical data, phone calls, faxing information, emails), it will be done with special safeguards to insure confidentiality. Initial ___

Teletherapy

Teletherapy is therapy conducted using interactive audio and video as a method of therapeutic communication. I understand that I have the following rights with respect to teletherapy:

1. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the confidentiality section of this document. Initial ___

2. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Miki Johnston, LCSW and the client, that: a) the transmission of my information could be disrupted or distorted by technical failures; b) the transmission of my information could be interrupted by unauthorized persons; c) and/or the electronic storage of my medical information could be accessed by unauthorized persons. Initial ___

3. In addition, I understand that teletherapy based services and care may not be as complete or a substitute for face-to-face services. I also understand that if Miki Johnston, LCSW, believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. Initial ___

4. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am

having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800. 273.TALK (8255) for free 24 hour hotline support. Initial ___

5. I understand that I am responsible for: a) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions; b) the information security on my computer; and c) arranging a location with sufficient privacy that is free from distractions or intrusions for my teletherapy session. Initial ____

6. Phone and video sessions are not always covered by insurance. I will appropriately code these services on your requested Statement of Services, but your insurance company may not cover these services. Initial ___

I have read the above information and agree to all policies and procedures. If the client is a minor, under the age of 18, the client's parent/legal guardian agrees to the terms of this contract on behalf of the child.

_____
Client Name (please print)

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature Date