Informed Consent

Introduction
This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents.

Confidentiality
All communications between you and me will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, I will not disclose information communicated privately to me by one family member, to any other family member without written permission.) There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. In addition, a federal law known as The Patriot Act of 2001 requires therapists, (and others), in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.
If you have been under the care of or are currently seeing another therapist for other issues a release of information may be requested. If you are currently under the care of an individual therapist and are participating in group therapy under my care a release of information will be requested.

Information about Me
At an appropriate time, we will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about my background, experience and professional orientation. I am a Licensed Professional Counselor, License number (LPC-5494).

Fees and Insurance
The fee for service is $130 per office (regular) therapy session; sessions are usually 50 minutes in length but can, in some cases, last a maximum of 60 minutes. The fee for the initial intake appointment, a 90-minute session, is $150 and is a one-time fee. The fee for service is $140 per in home therapy session, (within Ada County). Fees are payable at the time that services are rendered. Please ask me if you wish to discuss a written agreement that specifies an alternative payment procedure. Please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance company, payment will be provided by you at the time of service and I will provide a Super Bill at the end of each month for which you will submit to your insurance for reimbursement. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain Diagnosable Mental Disorders. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although

I am happy to assist your efforts to seek insurance reimbursement, we are unable to guarantee whether your insurance will provide payment for the services provided to you. I am an in network provider for Regence Blue Shield of Idaho and you will be responsible for your co-pay at the time of the appointment; please refer to your mental health co-pay for the determined amount; if you are unsure of the amount of your co-pay, please contact Regence Blue Shield of Idaho and inquire. Please discuss any questions or concerns that you may have about this with me. If for some reason you find that you are unable to continue paying for your therapy, you should inform me ASAP. I will help you to consider any options that may be available to you at that time. If other insurance arrangements are made due to financial hardship, you are responsible for the full bill if reimbursement has not been provided by insurance within 60 days of billing.
This is typically due to a simple delay in processing by the insurance company.

Minors and Confidentiality
Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, I, in the exercise of my professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

Appointment Scheduling and Cancellation Policies
Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different frequency of therapy, depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify me at least 24 hours in advance of your appointment. If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session, except in the case of emergencies. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies
Telephone, Email and text message consultations between office visits are welcomed for established patients who have signed this agreement.
Rates will apply as follows:

- Internet (live) counseling = $130/session (50 minutes)
- Telephonic counseling =$25/15 minutes
- Email counseling = no charge
- Text Message counseling= no charge

My belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Friday) within 24 hours. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 9-1-1 to request emergency assistance.

Therapist Communications
I may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. *Please be sure to inform me if you do **not** wish to be contacted at a particular time or place, or by a particular means.*

My therapist may communicate with me by _____ @_____.

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. I will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion. Due to the varying nature and severity of issues and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result. I will see you weekly or more frequently if we determine appropriate, however every other week sessions are not scheduled. The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask me to address any questions or concerns that you have about this information before you sign.

Printed Name and Signature of Client Today's Date