# Westport Counseling & Therapy

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## Informed Consent for Psychotherapy

### New Client

Welcome! Thank you for choosing me as your psychotherapist. This is an opportunity to acquaint you with information relevant to psychotherapy, confidentiality, and office policies. I will be glad to answer any questions you have regarding any of these policies.

### About Therapy

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with internal conflicts in order to achieve more satisfying personal and interpersonal relationships. This purpose is accomplished by:

1. Increasing personal awareness of obstacles and strengths
2. Taking personal responsibility to make the changes necessary to attain your goals
3. Identifying specific psychotherapy goals
4. Utilizing all available community, medical, and self-help resources

### Appointments

Appointments are usually scheduled for 45-55 minutes. The sessions are by appointment only. Clients are generally seen on a weekly or biweekly. You may leave me a voicemail 24 hours a day but I typically only return calls during regular business hours, Monday through Friday. In the event of an emergency, you may call 911 or your local emergency room.

### Confidentiality

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child, elderly person or a disabled person
2. When I believe you are in danger of harming yourself or another person or you are unable to care for yourself
3. If you report that you intend to physically injure someone, the law requires me to inform that person as well as the legal authorities
4. If I am ordered by a court to release information as part of a legal involvement
5. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
6. In natural disasters whereby protected records may become exposed
7. As required by the Patriot Act
8. When otherwise required by law

You may be asked to sign a Release of Information so that I may speak with other healthcare professionals or to family members.

### Record Keeping

A clinical chart is maintained describing your counseling goals and progress, dates of services and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

### Fees

Each 45-55 minute session is $150.00 unless otherwise discussed. Patients with insurance are responsible to pay their co-pay at each session. Legal services that include talking with an attorney, writing reports and/or court time will be billed at a separate agreed upon rate.

**We have made an agreed upon rate of $_____ per 45-55 minute session. Initials _____**

## Payments
Payment is due at the time of the session unless other arrangements have been made. You will be responsible for your insurance deductibles, co-insurance, and co-payments. I accept cash, check, credit cards, or payment via Paypal. Please note that with each Paypal transaction, Paypal charges a transaction fee.

## Telephonic Consultations
Sometimes having a face-to-face meeting is not always possible. As such, with enough advance notice, I can and will facilitate a counseling session with you over the phone or FaceTime. The charge for this is the same as it would be if you came into the office. A full hour with me on the phone may not be necessary. You can also have a phone consultation with me that is prorated for the time we do spend on the phone based on your regular hourly rate.

## Cancellations and Missed Appointments
You will be billed for any sessions that you cancel with less than 24 hours notice. You may leave messages 24 hours per day. If you do not give 24 hours notice, you will be billed the full rate of a session – not just a co-payment. Insurance companies do not reimburse for failed appointments.

**Initials** _____

## 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 me immediately to discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and the Board of Behavioral Sciences to file a complaint if you so choose.

## Treatment Agreement
It is important that we develop a treatment plan so that both parties know what we are working on and with whom we are working. Usually our first few sessions are understood as assessment sessions during which time we mutually decide on how we are going to work together. We need to decide what is the issue or diagnosis we are working with and what kind of interventions or treatment modalities will be best for you. A referral to an outside support group or treatment program may be suggested or required. For example, a referral to a substance abuse recovery group, a grieving support group or a parenting group may be a necessary part of your treatment plan. At times you will be asked to complete assignments outside of the therapy hour. These might include journaling, thought and behavior tracking logs, practicing stress reduction techniques, practicing assertive communication skills or attending various support groups. The outside assignments are essential aspects of your treatment and failure to follow through may seriously impair my ability to be helpful to you. We will then have to reassess our treatment plan and decide if I can still be helpful to you. You are expected to take an active role in therapy, which includes regular feedback to your therapist as to your progress. Treatment surveys will be provided for feedback.

## Consent for Counseling
By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction.

*I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or counseling. I understand that I may withdraw from counseling at any time. I have also received a copy of the office* ***Notice of Privacy Practices,*** *which describes how medical information about me may be used and disclosed and how I can get access to this information.*

*I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of medical benefits and government benefits to Lapde So.*

**Name** (please print): _____

**Client Signature**: _____ **Date**: _____

**Therapist Signature**: _____ **Date**: _____