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CLIENT INFORMATION AND CONSENT

Client Information

Welcome to my practice. I appreciate you giving me the opportunity to help you.

This packet answers some questions clients often ask about any therapy practice. It is important to me that you know how we will work together. Please read this carefully and sign. We will review this information during our first appointment. Feel free to ask any questions you may have regarding this form.

THERAPIST

I am a Licensed Clinical Social Worker in the State of Missouri. I am engaged in private practice providing mental health services to clients directly and as an independent contractor/provider to many insurance companies.

PSYCHOTHERAPY SERVICES

I view therapy as a collaboration among you, your family members (if they are part of the services) and myself. We will work together to develop a better understanding of you, your goals and your values. Therapy may help you define areas for improving relationships, coping with stress or anxiety, enhancing communication and listening skills, or changing old behaviors and developing new ones. Working with a therapist can help provide support, insight, and new strategies to navigate through all types of challenges. It requires your best efforts to change thoughts, feelings or behaviors. It also requires that you observe some of your behaviors and practice some of the new skills that you will learn in our sessions. I might ask you to do exercises, keep records, or do other tasks to deepen your learning. We will develop a treatment plan of goals and areas that you would like to improve. Together, we will look at progress made and examine areas that need to be developed.

APPOINTMENTS

Appointments are made by calling my office 314-993-7616 Monday through Friday between the hours of 9:00am and 9:00pm. Please call to cancel or reschedule at least **24 hours in advance**, or you will be charged for the missed appointment. Third party payments will not cover or reimburse for missed appointments. You will be expected to pay these charges out of pocket.

NUMBER OF VISITS

The number of sessions needed depends on many factors including but not limited to managed care or health insurance coverage, Employee Assistance Program (EAP) benefits, or treatment plan goals. These will be discussed during your sessions.

LENGTH OF VISITS

For clients using their mental health or EAP benefits, therapy sessions are (as of 01/01/2013) 45 minutes in length. For those “fee-for-service” clients (opting to not use their mental health benefits)

sessions are 50 minutes in length. A 60 or 75 minute session may be scheduled depending on need and insurance benefits.

WHAT TO EXPECT FROM OUR RELATIONSHIP

As a professional, I will use my best knowledge and skills to help you. This includes following the standards of the National Association of Social Workers (NASW). In your best interests, the NASW puts limits on the relationship between a therapist and a client and I will abide by them. These limits include the following:

- Our relationship is a professional and therapeutic relationship. In order to preserve this relationship, I cannot have any other role in your life. I am not in a position to be your friend or have a social or personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between us except in unusual circumstances.
- State laws and the standards of NASW require me to keep what you tell me confidential. You can trust me not to tell anyone else what you tell me, except in certain limited situations. See the "Confidentiality" section of this handout. I try not to reveal who my clients are to maintain this confidentiality. If we meet on the street or socially, I will not initiate the conversation or talk very much. My behavior will not be a personal reaction to you, but a way to maintain the confidentiality of our relationship.

CANCELLATIONS

If you need to cancel an appointment, I require notification **at least 24 hours** in advance or you will be billed directly for the full cost of your missed session. If you are using insurance, you will be charged the **CONTRACTED RATE** for the cost of your missed session (e.g., if the contracted rate for United Health Care is $60/session, and your copayment is $25, you will be charged $60 for the missed session). You may leave a message on the voice mail, which does have a time stamp and is checked after regular office hours. In the case of sickness, notice **MUST** be given **before 9:00am** on the day of your appointment to avoid being charged.

When you schedule an appointment, I make a commitment to see you during that time, and you commit to pay for the time that I have reserved especially for you. If you miss more than three appointments in a row, or if canceling on short notice becomes habitual, I may choose to terminate our treatment relationship.

PAYMENT FOR SERVICES

Payment for services is an important part of any professional relationship. As of 1/1/15 my fee for service client rates are as follows:

- Initial evaluation - $120 for 60 minutes
- Psychotherapy - $100 for 45 minutes
- Psychotherapy - $120 for 60 minutes
- Couples psychotherapy - $100 for 45 minutes
- Family therapy - $100 for 45 minutes

You will be responsible for full payment of your account, and you will be responsible for payment of all charges. Full payment or copayment is expected at the time services are provided. Payment can be in the form of cash or check. A fee of $30 will be charged for all returned checks.

- ***Insurance and EAP Services:*** I accept insurance from most companies. The best way to find out if your insurance will pay for services is to look on the insurance company's website or call them and ask about what your plan specifically covers. You will need to give them my name and credentials when you call.

    - Different co-payments or co-insurance payments are required by various group coverage plans. Your co-payment is based on the Mental Health Policy selected by your employer or purchased by you. In addition, the co-payment may be different for the first visit than for subsequent visits. You may also be responsible for the contracted rate (as deemed by the insurance company) until all your yearly insurance deductibles have been met.

    - Prior to your first visit, you are responsible for checking your insurance and EAP benefits including coverage, deductibles, preauthorization, number of sessions permitted, payment rates, co-payments and co-insurance.

    - Co-payments are collected at the time of service in the form of cash or check. If, at any point in time, a co-payment, statement or preauthorization has been adjusted, you will be notified. You will be required to pay the difference or will be given a credit if overbilled. I will make you aware of any credits or adjustments from the insurance company. If your insurance does not pay for services, you will be responsible for the balance due.

- ***Telephone Consultations:*** Telephone consultations may be needed at times in our therapy. Insurance does not pay for telephone consultations. Direct telephone contact over 10 minutes will be billed on a prorated basis at $2.00 per minute. If I need to have long telephone conferences with other professionals as part of your or your family's treatment, you will be billed for these at the same rate as regular therapy services. There is no charge for calls about appointments or similar business.

- ***Reports:*** I will not charge you for my time spent making routine reports to the insurance company. I will charge you for my time for any reports made to schools or physicians.

- ***Other Services:*** Charges for other services, including but not limited to hospital visits and consultations with other therapists (beyond 10 minutes) will be based on the time involved in providing the service at my regular fee schedule. Some services may require payment in advance.

- ***Excluded Services:*** At this time, I will not take cases involved in legal or court-related matters. I am not a custody evaluator and cannot make any recommendations on custody matters. Due to the sensitive nature of court-related issues, and the time it would take away from my normal work day, I also ask that clients waive their right to subpoena me to court for any reason. It is my desire and ethical obligation to preserve confidentiality and trust that is established in the therapeutic relationship. Having me and/or my records subpoenaed often damages this. Conducting expert witness testimony is not my expertise. I can refer you to another professional who can provide this service if needed. I, the client, waive my right to subpoena the therapist or her records for this purpose. *Initial* _____

CONFIDENTIALITY

Sessions between a therapist and a client are both privileged and confidential. No information will be released without the client's written consent unless mandated by law.

- There are, however, exceptions based on professional ethics, state law, and federal regulation (HIPAA). These exceptions include:

    1. mandatory legal obligation, such as child abuse or elder abuse;
    2. court subpoena, cooperating with law enforcement officers, under certain circumstances;
    3. suspected personal danger to yourself or an identified victim;
    4. information required by insurance companies for payment (for which you consented);
    5. information provided to parents, if client is a minor;
    6. consultation with other professionals in order to aid in the counseling/treatment process (identifying information will be withheld unless written permission is given);
    7. to defend myself against a claim of improper care.

- Release of information to other individuals, agencies or professionals may be permitted only with your written consent.
- Additional policies pertaining to HIPAA are described in the "Notice of Privacy Practices."
- When meeting with couples, in order to provide the safest environment possible, it is my policy not to release information for divorce proceedings if they may ensue. When you sign this disclosure, you are agreeing not to subpoena my records in order to defame the character of your spouse in the process of a divorce, except in cases of clear, observable abuse that I have personally witnessed.
- In order to provide you with the highest quality service possible, I consult regularly with other professionals about my work with clients. All names and identifying information will be changed and kept private.
- I keep all adult records for seven years after the last date of service. All records for children under 18 are kept for seven years after they turn 18. After that, they are shredded to protect your confidentiality.
- An insurance company will sometimes request information on symptoms, diagnoses, and treatment methods. This information will become part of your permanent medical record. I will inform you should this occur.

<u>Client Informed Consent</u>

Please initial each item to indicate that you have read and understand it.

DUTY TO WARN

In the event that the undersigned therapist believes that I, the client, am in danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person (s) in danger and to **contact the following persons**, in addition to medical and law enforcement personnel:

Contact Name: _____ Phone number: _____
Relationship: _____
Contact Name: _____ Phone Number: _____
Relationship: _____

Initial _____

RISKS OF THERAPY

Therapy is the Greek word for change. As the client, you may learn things about yourself that you may not like. Often, growth cannot occur until you experience and confront issues that may make you feel sad, sorrow, anger, anxiety or pain. There is a risk that clients will experience uncomfortable feelings. Therapy may disrupt a marital relationship and sometimes may even lead to a divorce. Sometimes, a client's problems or child's behavior may temporarily worsen after the beginning of treatment. Even with our best efforts, there is a risk that therapy may not work out well for you.

I, the client, understand that no guarantees have been made to me as to the results of treatment or of any procedures provided by my therapist. I am assured that the therapist will not perform any services that are in violation of the code of professional responsibilities which govern this profession. *Initial* _____

AFTER HOURS EMERGENCIES

I, the client, understand that the undersigned therapist does not focus on crisis counseling and expects her clients to be able to keep themselves safe. In case of an emergency and I am unable to reach the therapist, I can contact Life Crisis Services at (314) 647-4357, dial 911 or go to the nearest hospital emergency room. *Initial* _____

WAIVER OF FULL DISCLOSURE

I, the client, have been advised that I have a right to copies of my entire file but acknowledge that some information may not be in my best interest to review. In the event my therapist, in the exercise of her professional judgment, determines that information in my file is injurious to me, **I, the client, waive my right** to obtain such potentially injurious information and release my therapist from any and all such claims, damages and causes of action that I suffer or could assert for her refusal to provide me with the information requested. *Initial* _____

THERAPIST'S INCAPACITY, DEATH, OR RETIREMENT

I, the client, acknowledge that in the event that the undersigned therapist becomes incapacitated, dies or retires it will become necessary for another therapist to take possession of my file and records. By signing this information and consent form, I give my consent to allow another licensed mental health professional selected by the undersigned therapist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice. *Initial* _____

CONSENT TO TREATMENT

I, _____ (name of client), voluntarily, agree to receive mental health assessment, care, treatment, or services, and authorize my therapist, Laurie Furman, MS, MSW, LCSW of Furman Family Counseling, LLC to provide such care, treatment, or services as are considered necessary and advisable. I understand that I will participate in the planning of my care, treatment, or services.

I am aware that I may discontinue care, treatment or services with my therapist at any time.

I understand that no guarantees have been made to me as to the results of treatment or of any procedures provided by my therapist.

BY SIGNING THIS CLIENT INFORMATION AND CONSENT FORM, I, THE UNDERSIGNED CLIENT, ACKNOWLEDGE THAT I HAVE BOTH READ (OR HAVE HAD READ TO ME) AND UNDERSTOOD ALL THE TERMS AND INFORMATION ABOUT THE THERAPY SERVICES THAT I AM RECEIVING. I HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION.

_____ _____

Signature of client (or person acting for client) **Date**

_____

Printed name

Release of Liability

I, do for myself and assigns hereby and unconditionally, release and discharge Laurie Furman, MS, MSW, LCSW or Furman Family Counseling, LLC and their employees heirs and assigns, jointly and severally from any action, suit, claim, or demand I have or may ever have against them due to my participation in therapy performed by them.

_____ _____

Signature of client (or person acting for client) **Date**

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist **Date**

___ Copy accepted by client ____ Copy kept by therapist

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