Informed Consent for Services

Counseling is my attempt to help you address your mental, emotional and behavioral health goals, however we cannot make any guarantee as to outcome as each individual case and course of treatment will be unique to your needs as the client. This document contains important information about my professional services and business policies. Please discuss any questions you may have with me. When this document is signed, it will represent an agreement between us.
My credentials are: Licensed Mental Health Counselor: FL MH13882 & Qualified Supervisor
Registered Art Therapist: ATR 13-117
EMDR Trained Clinician & Adoption Competency Certificate

All treatment is provided in collaborative consultation with the client about how to address presenting concerns, any diagnoses present, and the recommended course of treatment. Sometimes clients may be better served elsewhere and as appropriate, referrals will be made. Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of one's life experience, you may experience uncomfortable emotions at times. On the other hand, therapy has also been shown to have benefits for those who participate such as improvements in relationships, problem solving, and reductions in feelings of distress but there is no guarantee regarding your experience.
Treatment begins with an evaluation of needs which could take a few sessions, and involve discussion of your symptoms, personal history, treatment goals and collaborative discussion about a treatment plan to follow if you decide to continue with therapy. If at the end of this evaluation period, I will notify you if I believe I am not the right therapist for you, or that your needs could be better served elsewhere. If this is the case, I will give you referrals to other practitioners who may be better suited to help you.

Contact

1. Email is not a secure method of communication and does not protect your confidentiality, therefore it will not be utilized for communication regarding therapeutic services.
2. Social media and telecommunication: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.
3. Please call the office number or utilize the secure patient portal for messaging if you need me.

4. I am not often immediately available by telephone as this practice only provides services during limited business hours, and I may be with another client. I will check voicemail regularly and make every effort to return your call as soon as possible. When experiencing an urgent need, you agree to call a local support hotline such as 2-1-1 Big Bend, 9-8-8 Suicide hotline, or in an emergency to call 9-1-1 or report to the nearest emergency room.

Confidentiality (for adult clients)

The privacy of communication between a client and their therapist is protected by law. Client personal data, sessions, and records are Confidential, but there are exceptions:

1. When there is imminent danger to the client or to others related to suicide or homicide. If a client threatens to harm themselves, I may be obligated to seek hospitalization for them, or to contact others who can help provide protection. If I believe a client is threatening serious bodily harm to another person, I may be required to take protective action such as notifying the potential victim, contacting the police, or seeking hospitalization for the client.
2. When there is reasonable suspicion that a minor child, elderly person, or adult with a disability may be experiencing abuse (physical, sexual, abandonment, neglect, or exploitation). It is mandated by law that this suspicion be reported so that the circumstance can be investigated by trained parties to ensure safety and provision of resources for all involved. Past abuse must be reported when there is any possibility of current danger to any child, elderly or disabled person (e.g. when a child currently lives with the past abuser and there is reasonable suspicion of current danger to that child).
3. When a client is a minor or an incapacitated adult, information may be released to parent or guardian.
4. When a court order signed by a judge is received that orders release of information.
5. When the client requests or signs a written Release of Information form in order to share clinical diagnosis, treatment summary, or clinical record for the purposes of coordinating care, consultation with other providers or procuring other support services. If the client authorizes release of confidential information, all guidelines of professional ethics codes and legal mandates will be followed.
6. When present or future work is in a professionally regulated area (i.e. medicine, nursing, law, etc.) or requires government security clearance, please be advised that those regulatory boards may require you to disclose treatment history and to authorize release of records or treatment summary as part of the application or employment procedures. In this event, the client will sign the requisite Release of Information (ROI) and will review any such release of treatment information with the clinician.

Termination

1. Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion

with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

2. Should you fail to schedule an appointment for four consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Available Services and Treatment Modalities

Individual Therapy

1. The first appointment includes a biopsychosocial interview, also known as an intake. This serves as the beginning stages of the needs assessment and may contain minimal intervention or guidance as I need to become familiar with you as the client and your symptoms prior to making recommendations.

2. The standard "therapy hour" is 50 minutes, and the fee is $125. You will be expected to pay for each session at the time of the appointment unless prior arrangements have been made and agreed upon.
3. Appointments are scheduled directly by your clinician. Once an appointment is scheduled, you will be expected to pay for it unless you provided 24 hours advance notice of the cancellation. If cancelling after this window of time, you will incur a late cancellation fee of $25.
4. No-shows without prior notice will be required to pay the full session fee. Late arrivals will only be able to meet with clinician for the time remaining of the scheduled appointment and will still be expected to pay the session fee. In cases where it will be antitherapeutic to meet for an abbreviated time, rescheduling will be discussed. (The fee may be waived at clinician's discretion in response to unpredictable and extenuating circumstances which prevented attendance)
5. Other professional services may incur a fee as well, and this fee schedule can be discussed should those services be requested. You have the right to know the fee for services you request prior to their completion.
6. Any limitations regarding payment for services and/or insurance coverage should be discussed up front. I will provide you with documentation necessary to seek insurance reimbursement for services. However, this coverage is not guaranteed and you (not your insurance company) are responsible for full payment of fees. Therefore, you should confirm what services your insurance policy covers beforehand, and determine any limitations to the number of sessions or form of treatment which will be reimbursed. Insurance companies may also require that I provide them with your clinicial diagnosis or additional information such as treatment plan,

progress notes, or treatment summaries. Although insurance companies are expected to protect health information, I have no control over what they do with it once it is in their hands. *You understand, that by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary.*

Group Therapy

Group therapy is an offered form of treatment with its own guidelines and procedures which are included as an addendum to this document. If interested in group therapy only, a group screening appointment will be scheduled to review presenting concerns, any relevant diagnoses, treatment goals for group, and to review group guidelines and procedures.

Individual or group treatment could include the following modalities based on my training and professional credentials if assessed to be clinically appropriate and mutually agreed upon by clinician and client

Art Therapy

Art Therapy involves creation of an art product as part of the confidential therapeutic relationship. When agreeing to participate in art therapy, the artworks are owned by the client, but a reproduction will be created to be stored with the clinical record. As mandated by Florida law, this record will be maintained for seven years after the last point of contact. Upon termination of treatment, clients will have 30 days to claim artwork that has not previously been collected.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a form of therapy that utilizes bilateral stimulation (BLS) in the form of eye movements, tapping, or auditory stimulation to accelerate the brain's capacity to process and heal troubling memories, thoughts, or feelings. The stimulation simulates Rapid Eye Movement during sleep and required two parts of the brain to work in conjunction to reintegrate a memory.

1. Reprocessing may trigger associated memories and lead to experiencing physical sensations, emotions, or flashbacks during or after EMDR treatment.
2. I understand the need to disclose to my provider and consult with a physician prior to participating in EMDR therapy if I have a history of current eye problems, diagnosed heart disease, elevated blood pressure or at risk of stroke, heart attack, seizure, or other conditions which may put me at medical risk. BLS will be discontinued if eye pain is reported.
3. I understand that before participating in EMDR, I need to discuss any upcoming legal court cases where testimony is required as it may be beneficial to postpone EMDR treatment as the traumatic material being processed using EMDR may fade or become less salient impacting the individuals ability to give testimony in court.
4. Some medications may reduce the effectiveness of EMDR and this should be discussed with medical provider. Certain drug use also contraindicates use of EMDR treatment.

5. Evaluation for Dissociative Disorders will be part of the preparation stage for EMDR treatment as EMDR could trigger these symptoms, but also may be beneficial in reducing or resolving them.
6. Research has shown EMDR to be effective for the treatment of post-traumatic stress, phobias, panic attacks, anxiety disorders, stress, sexual & physical abuse, disturbing memories, complicated grief, and addictions.

By signing this consent form, I indicate that I have read it, and agree to abide by its terms during our professional relationship.

I have accepted a copy of this form (yes) (no)

Client name (printed) ________________________ Date of Birth ____________

Signature of Client ________________________ Date Signed ____________