



Informed Consent for Therapy Services

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. **You should evaluate this information and make your own assessment about whether you feel comfortable working with me.** If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice. **If you miss a session without canceling, or cancel with less than 48 hour notice, my policy is to collect the \$99.00 missed session fee.** It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. If you are late 20 or more minutes to your session, that will have to be considered a missed appointment as insurance companies do not reimburse for partial sessions.

Therapy can only be helpful if you attend, therefore if you are having difficulty attending appointments, and/or canceling frequently, this will prompt a discussion about whether now is the right time for you to engage in therapy.

I understand the 48 hour notice and accept the \$99 missed appointment fee. Initials: _____

PROFESSIONAL FEES

The standard fee for the initial intake is \$220 and each subsequent individual session is \$180.00 and couple's session is \$200. Fees may increase yearly, and you will be informed of any changes with at least 30 days notice. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by credit card. Fees may also be charged for clinical phone calls, consultations, and letter writing at a prorated rate. These fees are rarely covered by insurance and will likely need to be paid out of pocket. **If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.**

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. **With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.**

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-5. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by credit card.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement.

Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

I understand and accept how my information (including diagnosis) will be shared with insurance.

Initials: _____

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure program online. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

Everything we do together is protected by confidentiality, except under rare circumstances that I am concerned for your safety, or you threaten to harm another person. I am also mandated by law to report any suspected instances of abuse or neglect of a child, disabled adult or elderly person. For more specific information please see the HIPAA policy and privacy form that has already been provided to you. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

I understand and accept the limits of confidentiality.

Initials: _____

CONTACTING ME

The best way to contact me is through email (Danya@danyagoodman.com), I will respond within two business days. I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform

you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, relationship status, color, gender expression, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients, including through social media.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____ Date: _____
Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Description of Personal Representative's Authority _____