CrossWay Counseling Center Inc.

Youth Informed Consent for Therapy Services

Welcome to our practice! This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

What to expect

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, we will keep the information you share with me in our sessions confidential, unless we have your written consent to disclose certain information. There are, however, *important exceptions* to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, we are required by law or by the guidelines of our profession to disclose information whether or not we have your permission. We have listed some of these below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm to yourself or others, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe the threat to be. I must make sure that you are protected from harming yourself or others.

>You are doing things that could cause serious harm to you or somebody else, even if you do not intend to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally- or that you have been abused in the past. In this situation, I am required by law to report the abuse.

>You are involved in a court case and a request has been made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Confidentiality

Our policies about confidentiality, as well as other information about your privacy rights, are also fully described in a separate document entitled Notice of Privacy Practices. You acknowledge that 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.

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. Your therapist has 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 your sessions.

The first 1-2 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 our 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 50 – 55 minutes in duration, once per week at a time we agree upon, although some sessions may be more, or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. When a client does not show up for their scheduled appointment, it creates an unused appointment slot that could have been used for another client. **If you need to cancel or reschedule a session, we require 24 hours notice**.

Professional Fees

The standard fee for the Initial Psychiatric Diagnostic Evaluation is $230.00 and each subsequent individual session is $170.00. A more complete professional fee list can be provided for you upon your request. You are responsible for paying your deductible or co-pay portion at the time of your session unless prior arrangements have been made. Payment can be made by cash, check or credit card. Any checks returned to our office are subject to an additional fee of $35.00. If you refuse to pay your debt, we reserve the right to use an outside 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, our billing professional 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 us 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 the complications you are seeking treatment for and whether they are short-term or long-term.) Sometimes I have to provide additional clinical information such as treatment plans or summaries. This information will become part of the insurance company files and may be stored in a computer. Please be advised that we have no control over this information once it is released to your insurance company. We will provide you with a copy of any report we 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 fees. Many policies leave a percentage of the fee (co-insurance) or a flat dollar amount (co-payment) to be covered by the

patient. Either amount is to be paid at the time of the visit by check, cash or credit card. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions until your deductible has been met: the deductible amount may also need to be met at the start of each year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. If we are not a participating provider for your insurance plan we will make every effort to join your network. Until such time as we are accepted in to your network and you choose to continue with treatment regardless, please be aware that not all insurance companies reimburse for out-of-network providers.

Professional Records

Your therapist is required to keep appropriate record of the psychological services that they provide to you. Your records are maintained in a secure location in our office. We 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 we receive from other providers, copies of records we 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, we recommend that you initially review them with your therapist, or have them forwarded to another mental health professional to discuss the contents. If your therapist refuses your request for access to your records, you have a right to have that decision reviewed by another mental health professional, which your therapist will discuss with you upon your request. You also have the right to request that a summary of your file be made available to any other health care provider at your written request.

Parent and Minors

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy to not provide treatment to a youth under age 13 unless s/he agrees that we can share information we consider necessary with the parent. For children 13 and older, we request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the youth's agreement, unless the therapist feels there is a safety concern (see also section on Confidentiality for exceptions), in which case your therapist will make every effort to notify the child of their intention to disclose information ahead of time and make every effort to handle any objections that are raised.

Contacting your Therapist

Your therapist may not always be immediately available by phone. They do not answer their phones while in session or otherwise unavailable. At these times, you may leave a message on their confidential voicemail (your therapist will provide you with their individual phone number) and your call will be returned as soon as possible for those matters that are urgent. Your therapist 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 their clients in their absence.

LATE CANCELLATION OR NO SHOW POLICY (Please See Separate Policy)

You must cancel your scheduled appointment no less than 24 hours prior to your appointment.

Text Message Service

Text message reminders are available if you would like to sign up for this service. However, these are provided as a courtesy to you and are not intended for you to rely on. You will be required to attend or call to reschedule in the event that there is an error in the system.

Other Rights

If you are unhappy with what is happening in therapy, we hope that you will talk with your therapist so that they can respond to your concerns. Such concerns will be taken seriously and handled with care and respect. You may also request that your therapist refer you to another therapist and you are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about your therapist's specific training and experience.

Consent to Psychotherapy
&
Parent Agreement to Respect Privacy

Adolescent therapy client

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

____ ________________________
Parent / Legal Guardian Date

____
Printed Name Parent / Legal Guardian

____ ________________________
Youth Signature (age 13 and older) Date

Parent/Guardian:

/__/ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

/__/ Although I know I have the legal right to request written medical records since my child is a minor, I agree NOT to request these records in order to respect the confidentiality of my adolescent's treatment.

/__/ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with a consultant/supervisor.

Parent Signature ____ Date ______________________

Parent Signature ____ Date ______________________

Therapist signature ______________________________________ Date ______________________