Practice Locations in Coeur d'Alene, ID and Williamsburg, VA
Phone: (757) 645-7722, Fax: (757) 645-2808
www.safeharborcounselingcenter.com

INFORMED CONSENT FOR PSYCHOTHERAPY

General Information: The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process: You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process and the strength of the therapeutic relationship. As I get to know you and the circumstances that have brought you and/or your family to counseling, you can expect an individualized, strengths-based, and holistic approach, as there is no one right answer and everyone is different. Therapy is a collaborative process and research indicates that finding a "good fit" between the therapist and client is essential in achieving a positive outcome. Consequently, throughout therapy I will seek feedback from you about whether I am addressing your needs and whether the approach I am using is helpful for you, and I will make an effort to adjust what I am doing to meet your needs and achieve the results and outcome you desire. If we determine that therapy is not helping, or that we do not have a "good fit", I will assist you in exploring other alternatives

The therapeutic process may be uncomfortable or unsettling at times. Making changes, even positive changes, can be difficult and takes time. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. However, if difficult feelings or experiences result as a part of therapy, I will support you and do my best to provide compassion and understanding while helping you work through and productively resolve them.

****Confidentiality**: ****The session content and all relevant materials to your treatment will be kept confidential by me, unless you request in writing to have all or portions of such content released to specifically named person/persons. However, there are certain limitations to client held privilege and confidentiality which are summarized below, and outlined in more detail in the "Notice of Privacy Practices" which I have provided to you:

1. I have a "duty to protect", which means I will take steps to address threats of suicide, homicide, or serious bodily harm, which may include release of confidential information.
2. "Mandatory reporting" requires that I report suspected child, elder, or dependent adult abuse to appropriate authorities.
3. I am required to comply with legally authorized disclosures, including subpoenas or court orders.
4. I may release information about your treatment as part of the treatment payment process and health care operations.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

****Payment Agreement: ****** Payment is due at the time services are rendered. Fees for services provided are listed below and are based upon based upon prevailing rates for the same services provided by other therapists in this area. The fee is billed to your

insurance company; the insurance company determines the fee it allows for the service (I accept this allowable fee, which is typically less than the fee submitted) and then pays a portion of the allowable fee. You are responsible for the remaining portion of the allowable fee, which is represented by your copay or coinsurance amount under your insurance plan. Following are the fees I submit to the insurance company:

Initial Evaluation - $155
45-minute Psychotherapy Session - $100
60-minute Psychotherapy Session - $150
Couples/Marriage or Family Therapy Session – $150

Your benefit information is given to the therapist by your insurance company and the therapist is not responsible for co-pays and/or deductibles that may differ from what was provided by the insurance during the insurance verification process. This consent also constitutes your agreement for the therapist to contact any third party payer for payment. Self-pay clients are responsible for the full amount of the session rate, unless otherwise agreed upon with the therapist directly. Reduced rates are determined on a case by case basis at the discretion of the therapist.

Appointments are scheduled as agreed upon between you and the therapist. Cancelling or rescheduling appointments requires appropriate notification at least 24 hours prior to your scheduled appointment time, except in cases of true emergencies. You will be charged a $65 fee for missed appointments or if not cancelled 24 hours in advance. Failure to make payment on an amount owed may result in removal from the therapist's schedule and may necessitate the initiation of collections procedures, including possible legal action to recover the amount owed.

****For More Information: **** You may seek additional information regarding practice policies, privacy, informed consent, services provided, and payment from the therapist directly.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____
Client or Parent/Legal Guardian Signature Date

_____ _____
Witness Signature Date

Practice Locations: 206 Ironwood Dr. #1012, Coeur d'Alene, ID 83814
1320 Richmond Rd. #1053, Williamsburg, VA 23185