Heart Centered Healing Connections

INFORMED CONSENT FOR SERVICES
CLIENT INFORMATION, SERVICE POLICIES

WELCOME! This document contains important information. It is intended to inform you of our professional services, your rights, policies, and State and Federal Laws.

THERAPY

You have taken a very positive step by deciding to seek therapy. It is our intention to help you get a better understanding of yourself, enhance your ability to cope more effectively and work to resolve any disruptive personal conflicts. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. 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. We cannot promise that your behavior or circumstance will change. We can promise to support you and do our very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself. It is important to mention that we are not crisis intervention focused therapists but rather, personal development and mental health support clinicians. Because of our frequent travels, We have limited our practice to those we can serve best within limited time frames. If there is a higher need, we will refer out to a clinician that can better meet the needs of clients who require more frequent visits/attention to address their immediate needs.

Initial here: _____

APPOINTMENTS

Appointments are usually scheduled for 55 minutes. Sessions may be scheduled for 25 or 75 minutes. Telephone Counseling sessions may be scheduled. Clients are usually seen weekly or more/less frequently as appropriate. You may discontinue treatment at any time, but please discuss this important decision with us.

Initial Here: _____

CANCELLATIONS AND MISSED APPOINTMENTS

You will be billed $75.00 for a session that you cancel (or Do not show for) with less than 24 hours notice. You may leave messages 24 hours per day. Please note that insurance companies generally do not reimburse for failed appointments so you will be responsible for this expense personally.

Initial here: _____

EMERGENCIES

In the event of an emergency where you are unable to connect with us, please know that you will need to choose one of the following:

1. Call 911, 211, or visit your local emergency room.

2. Contact the mobile crisis unit at 383-5777 (North of Southern Blvd.) or 637-2102 (South of Southern Blvd.).
3. Contact your psychiatrist or general practitioner.

Initial here: _____

Record Keeping

A clinical chart is maintained describing your condition, treatment, progress, dates and fees for sessions, and notes about each therapy session. Your records will not be released without your written consent, except as outlined in the Confidentiality section below.

Initial Here: _____

Limits of Confidentiality/Legal

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include but are not limited to:

1. The client authorizes a release of information with a signature.
2. Suspected abuse or neglect of a child, elderly person, or a disabled person.
3. The client presents as a physical danger to self or to others.
4. If you report that you intend to physically injure someone the law requires us to inform that person as well as legal authorities.
5. If we are ordered by a judge/ court to release information.
6. Your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
7. In natural disasters whereby protected records may become exposed.
8. When Otherwise required by LAW.

If you are under 18 years of age please be aware that the law provides both parents and or guardians the right to information regarding your treatment. It is our policy to request an agreement from parents / guardians that they allow our sessions to remain confidential. Absent such a guarantee of confidentiality, your child or adolescent may not trust me enough to establish a therapeutic relationship and treatment will be less effective. If the parents/guardian agrees we will provide them only with general information about our work together unless we feel there is a high risk that you will harm yourself or someone else. In this case we will notify them of our concern. We will also provide them a summary of your treatment when it is complete. Before we give them any information we will discuss the matter with you, if possible, and do our best to handle any objections you may have about what we are prepared to discuss.

9. We may find it helpful to consult other professionals about a case. During a consultation your identity will not be revealed and our professional peers are likewise bound by confidentiality.
10. If your account becomes overdue and you do not pay the amount due or work out a payment plan, we will reveal a limited amount of information about your treatment in taking legal measures to be paid. This information

will include your name, social security number, address, dates and type of treatment and the amount due. If any accounts are more than 90 days past due, we will add a 10% interest charge each month thereafter.
11. Please be advised that confidentiality cannot be guaranteed when communication utilizes technology. I.e., telephone, internet.

Initial here: _____

Legal/Court
It is our professional opinion that the relationship between the therapist and her client is for therapeutic purposes only. Therefore, in the event you are involved in divorce, child custody, or other legal matters, you agree that you will not have us subpoenaed to provide testimony or to provide any written documentation that would break this confidentiality. However, if you choose to waive this confidentiality agreement, you recognize that all information exchanged in confidence shall be open to the court for examination and therefore, you cannot hold us at fault for any reason, including but not limited to a judgment against the undersigned client. You also understand that any time spent on giving depositions or testimony, answering phone calls from attorneys, and any other work related to these legal proceedings, will be billed to the client for compensation.

Initial here: _____
or
Waive Confidentiality/Agree to compensation for legal time: _____
(complete waiver form)

Fees/Payments (Subject to change annually)
Our fee for a 45 minute session (90834) is $150.00 and $100.00 for a 25 minute session (90832). Anything over 53 (not to exceed 70 minutes) will be charged at $175.00 (90837).
The Standard Fee for phone consults over 10 minutes: $2/Minute
Payment is due at each session, unless prior arrangements have been made.

Initial here: _____

HYPNOTHERAPY/EMDR
We offer hypnotherapy and EMDR as treatment options. We find that hypnotherapy and EMDR are some of the the most effective and least expensive treatments available today. This is because they require fewer sessions overall to make a positive impact.
Elements of both Hypnotherapy and EMDR can be completed in session however for more in depth work, both **can be planned** to be two hours long. please note that if you choose the 2 hour session, most insurances will only cover the 1st hour of the session and therefore the second hour will need to be paid out of pocket at the insurance contracted rate.

I give consent to participate in hypnotherapy: _____

I give consent to participate in EMDR: _____

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DISCHARGE

There is an office policy that if there is no contact within a 90 day period of time, your case will be closed.

Initial here: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I have read and received a copy of the Notice of Privacy Practices and Client Rights documentation.

Initial Here: _____

Contact

I agree to be contacted on phone numbers on file. **Initial Here:** _____
I agree to be contacted by email /text. **Initial Here:** _____
I agree mail may be sent to the address on intake form. **Initial Here:** _____

Consent to receive email notifications

I consent to receive email notifications with updates and information related to services provided by Cathe Reiss. LCSW and/or Erika Cohane, LCSW of Heart Centered Healing Connections. Updates will be through constant contact.

Initial Here: _____

Consent for Treatment

By signing below, you are stating that you have read and understood this policy statement and have had your questions answered to your satisfaction. I accept, understand, and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. I understand that I may withdraw from treatment at any time.

Signature_____ Date_____

Name Printed_____ Date_____

Parent/Guardian Signature_____ Date_____

Name Printed_____Relationship to Client_____

Therapist/Provider_____ Date_____