Informed Consent for Psychological Assessment and Treatment

The Therapeutic Process and Your Rights as a Patient

Therapy will seek to meet goals established by all persons involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of family and personal goals and values; that may lead to a great maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits; however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

Counseling Process. You have the right to ask questions about any procedures used during therapy or about my qualifications as a therapist. If you wish I will also explain my approach and methods to you. We will be talking about what has led you to therapy and what you hope to achieve with this process as well as a number of questions I may have which will help me assess what is needed in your treatment.

At any time you have the right to decide not to receive therapeutic assistance from me. If you wish, I will provide you with the names of other qualified professionals whose services you might prefer at a cost comparable to my usual customary fee. The likelihood for success and continuity of your care improves when you feel it is a good fit with your therapist. It is okay to talk with me about it not being a good fit, and this will not affect in any way any continued care, referrals or follow up care by me, for you.

We will be discussing a discharge plan at some point throughout treatment. It is recommended that we "end" treatment versus "just not coming back", however you have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision without consulting me, so that your chart may be complete and all fees settled. The cancellation policy will still apply to any appointments scheduled and not attended. After 90 days of inactivity in the file, your chart will be moved to an inactive status. You are welcome to return for additional therapy services after the 90 day period, however you will be asked to complete new paperwork to ensure that we have the most up-to-date information on file.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen, but sometimes misunderstandings result in hurt feelings. I want to address any issues that may get in the way of therapy as soon as possible.

Confidentiality. One of the most important rights involves confidentiality. Within the limits of the law, information revealed by you during therapy will be kept strictly confidential within the practice and will not be revealed to any other outside person or agency without your written permission. Confidentiality also maintained by you agreeing you will not audio or video tape any of the interactions connected with your therapy (this includes phone calls as well).

You should know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situations are as follows: (a) if you threaten grave or bodily harm or death to another person, I am required by law to notify the appropriate parties or authorities; (b) if a court of law issues a legitimate

court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this

to the appropriate authority; (d) if you are in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; (e) disclosure required by the Board of Behavioral Health Examiners; (f) to comply

with the USA Patriot Act and other federal, state or local laws, and (g) if you are seeking payment through an insurance company, I will be required to reveal confidential information to them to ensure the carrier has the necessary information for reimbursement. Additionally, disclosure is required by the Arizona Board of Behavioral Health Examiners if I am notified of any inappropriate or unethical behavior as outlined in the state licensure guidelines by another licensed health care provider.

The HIPAA NOTICE OF PRIVACY PRACTICES, is available for your review if you request it. This packet also contains information about your right to access records and the details of the procedure to obtain them, should you choose to do so. Periodically, the HIPPA NOTICE OF PRIVACY PRACTICES may be revised in which will be posted in this office. It is imperative that you understand the limits to privacy and confidentiality before you begin treatment.

You have the right to know about the possible harmful results of therapy. In my years of psychotherapeutic service delivery and supervision, the only clear harm I have witnessed has resulted from client's use of medical insurance for psychotherapy and court involvement. Harmful events included: denial of insurability when applying for medical and disability insurance due to DSM 5 diagnosis (mental illness diagnosis, which are usually required for reimbursements under medical insurances); company (mis) control of information when claims are processed; loss of confidentiality due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "mental illness", including driver licenses applications, concealed weapons permits, and job applications and disclosure/(mis)interpretation of information indicating a particular court ruling.

There may be a time when our paths cross outside of the therapy session. I will maintain your confidentiality by making any gesture to you minimal if at all. It will be understood that you or I are not being rude, simply maintaining the therapeutic boundary. You may approach me if you like, although I will keep conversation minimal, again to maintain your privacy.

Health and Sickness Policy. It is the policy of Arrowhead Family Systems that we all work together to be healthy. The world is full of viruses and illnesses. If you are exhibiting any symptoms associated with the flu, a cold, allergies or any other respiratory illness, or have been recently exposed to someone actively contagious, please contact your provider and discuss other options for your appointment (ie. Telehealth). We will do the same for you. In the event you come in to the office with observable symptoms, your provider, in his or her discretion, may offer an alternative platform for your session or terminate the session and reschedule the appointment. Late cancellation fees will apply. If there are any questions, please communicate to your provider to discuss alternatives.

Social Media and Communications Policy. It is the policy of Arrowhead Family Systems that we will not "friend" you or "follow" you on any social media platforms (ie – Facebook, Twitter, LinkedIn etc.). I understand that Arrowhead Family Systems does have an internet presence and understand that you have the right to review our therapeutic services in an online forum (ie – Yelp, Healthgrades etc.). I encourage you to consider how doing this would compromise your right to confidentiality. If you choose to do this, it will be assumed that you are waiving your right to confidentiality.

Although I will try my best to always keep your confidentiality, please realize that certain methods of communication, such as email, phone and text can never be completely secure. Please try to utilize these methods of communication for scheduling purposes only. If you choose to communicate sensitive or therapeutic information via phone, text or email, it will be assumed that you realize the possibility for a breach in confidentiality and you knowingly accept this risk. All emails containing therapeutic information will become part of the therapeutic record.

Records. You have a right to review your records and must be requested in writing. Reasonable copy fees apply. I prefer to give you the documentation in person and discuss the information you request, versus mailing you the documents to minimize the possibility of misinterpretation. I do not keep any "secret notes", so please do not ask me to do so. Any part of your record in the files can be released to you, or any person or agency you designate so long as all necessary releases of information have been given and by all parties involved throughout the course of treatment. I will tell you at the time whether or not I think releasing the information in question to that person or agency might be harmful in any way to you.

Ordinarily, all communications and records created in the process of counseling are held in the strictest confidence. There are however, numerous exceptions to confidentiality as previously discussed. In addition, I do participate in a process whereby selected cases are discussed with other professional colleagues to facilitate my continued professional growth and include the benefit of a variety of professional expertise for your case. There is no identifying information released in this peer consultation process, strictly the dynamics of the problem and related treatment approaches and methods. Professional confidentiality is imposed on all involved in this process.

Availability of Services and Safety. My practice does not have the capability of providing emergency services or responding immediately to emergencies. Emergencies should be directed as appropriate to the respective need. For life threatening emergencies call 911. **For mental health emergencies you may contact Maricopa Crisis at (602) 222-9444 or Banner Help Line at (602) 254-4357**. I commit to you to being able to respond back to you as quickly as possible. There may be times that I am not able to respond back to you for a couple of days.

Court Involvement: More often than not, therapy is not useful in court proceedings. It innately compromises your confidentiality and progress in treatment. Testifying also compromises the underlying principle of therapy as a safe place to explore thoughts, feelings and life interactions that have initially led you to believing therapy would helpful
and productive. It is also outside our scope of practice to provide any recommendations regarding guardianship, custody, parenting time, parenting arrangements, etc. Appropriate releases of information by all parties involved in any part of the therapy are necessary for any disclosure. Considering that this is my position on court involvement, if I do receive a subpoena from a judge, I will comply to the nature of my ethical, professional and legal obligation. The fees associated with this process are to be determined before any legal involvement commences. Compensation for services will be assessed by the hour (in 15 min. increments) for any time spent in relation to the case (depositions, phone consults, written summaries and letters, testimony, drive/wait time etc.). If legal counsel is determined necessary for therapist's consultation or representation, you may also be responsible for assessed fees. Court related services are not a covered service by insurance providers.

Financial and Consent for Treatment: A typical therapy session lasts for 45-50 minutes. Should you need to extend the session you will be financially responsible for the additional time and need to consider any schedule conflict for the therapist. Additionally, although face-to-face therapy is preferred, should there be a need for phone counseling, consultation, or any other documentation requested reflecting any part of treatment, it will be charged the session fee in 15 minute increments. (please note: phone counseling is not covered by insurance).

I agree to enter into therapy with Dr. Kimberly Bailey, DBH, LMFT. The session rate is 150.00 for each 45-50 minute session if not using insurance or any other third party payor. Payment is due at the end of each session. If using insurance plan to cover costs of treatment, I assign insurance benefits for treatment to ***Dr. Kimberly Bailey, DBH, LMFT*** *and the contracted insurance agreements are in place. I authorize the release of necessary information to my insurance carrier or other agent preparing claims for payment. Co-payment, cost share, co insurance and/or Deductible is due at the end of each session. A 35.00 fee will be assessed for any check returned. If using an insurance out of network benefit, I will pay $50.00 upon completion of the initial assessment towards my deductible, cost share or copay. I am responsible for cooperating with my insurance company to support prompt payment.* ***I understand that if my insurance company does not pay for treatment, I will be responsible for payment in full.***

A 24-hour notice is required for cancellation of a scheduled appointment. If I do not meet this requirement, I agree to pay half of the full session fee. I understand that this will be my responsibility, not that of the third party payer. I understand that the therapist has the right to seek legal recourse to collect any unpaid balance.

I acknowledge that I have read and understand the above information and agree to participate in mental/behavioral health therapy based on the treatment plan agreed upon between my therapist and I. In the case of a minor child, I hereby affirm that I am the custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

Signatures: Patient (s) _____ Date : _____

_____ Date : _____

In the case of a minor child, please specify the following:

Full name of minor _____ DOB _____ Relationship _____ Full

name of minor _____ DOB _____ Relationship _____

For therapist use only – discussion of this consent has been included in the initial session and questions have been answered and/or additional materials have been given to client as requested.

_____Date _____ Dr. Kimberly Bailey, DBH, LMFT 10-200