• Gathered Connections Counseling

**THERAPY CONSENT, POLICIES, & AGREEMENT**

**PART I: THERAPEUTIC PROCESS**

**BENEFITS/OUTCOMES:** The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

**EXPECTATIONS:** For clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than you expect. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

**RISKS**: In working to achieve therapeutic benefits, clients must take action to achieve the desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

**STRUCTURE OF THERAPY**:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.

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- **Goal Development/Treatment Planning** – After gathering background information, we will collaborate to identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed, and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.
- **Clinical Supervision** Your therapist may be under clinical supervision to ensure the highest standard of care. This means that aspects of your case may be discussed with a supervising clinician who is bound by the same confidentiality standards. Supervision is a routine practice for therapists to enhance their skills and provide you with the best possible service.
- **Complaints and Concerns** If you have any complaints or concerns about your care, please discuss them directly with your therapist. We are committed to addressing any issues promptly and professionally. If you feel that your concerns are not adequately resolved, you may contact Michele Wiest-Alvarez, the practice owner, at 623-201-0719 for further assistance. Additionally, you may file a complaint with the Arizona Board of Behavioral Health Examiners at www.azbbhe.us or by calling (602) 542-1882.

**LENGTH OF THERAPY**: Therapy sessions are typically weekly or biweekly for 55 minutes depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

**APPOINTMENTS AND CANCELLATIONS**: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment prior to 24hrs of the scheduled appointment time. The charge for late cancellations /no shows is $80.00. If you cancel or reschedule more than twice, we may re-evaluate your needs, desires, and motivations for treatment at this time.***

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Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

**FEES**: The fee for the initial intake is $220.00 and each additional therapy session is $200.00 and if you are using insurance this will be billed at the time of service. There is a discounted rate of $135.00 per intake session and additional sessions if you choose not to use insurance. Payment is due at the time of service. Acceptable forms of payment are exact-amount cash, Zelle or credit/debit card including HSA/HRA card. If a scheduled appointment time is missed or cancelled less than 24 hours in advance, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the counseling relationship if more than 2 sessions are missed without proper notification a client **cancels three times consecutively.**

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. The cost per 15 minutes spent is $30.00. These services are not covered by insurance. All costs for services outside of session will be billed separately.

**TRIAL, COURT ORDERED APPEARANCES, LITIGATION**: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case.

To safeguard your confidentiality, I highly recommend avoiding any involvement in legal proceedings. Should you or your legal counsel request my presence in court, additional fees will apply. These fees cover not only court time but also any travel and document preparation involved. Please refer to the 'FEES' section above for specific cost details under "*collaborating with other professionals"*

**COPIES OF MEDICAL RECORDS**: Should you request a copy of your medical records; the cost is **2.00** per page. Payment for your medical records will be due prior to or upon receipt and can be picked up at the office. Please allow at **least 2 weeks** to prepare medical records.

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**PHONE CONTACTS AND EMERGENCIES**: Office hours are from Mon.-Thurs 10am - 6pm, Fri 10am - 5pm. If you need to contact the clinician for any reason, please call 623-201-0719, leave a voicemail, and a return call will be made 48 hours or as soon as possible). In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, **dial 911 or the local CRISIS HOTLINE 602-222-9444.**

**PART II: CONFIDENTIALITY*:***

Anything said in therapy is confidential and m-ay not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.

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- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/progress notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to the couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.

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- **Dual Relationships & Public**: Our relationship is strictly professional. To preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.

- **Social media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.

- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.**
    - **Do not use email for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment.

- **Software**

I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our psychotherapy sessions. I have chosen to use a note-taking system for psychotherapy as part of my effort to provide the best care to my clients. It provides me with an automatically generated transcript and summarization of our sessions. This system is HIPAA compliant and uses up-to-date encryption methods, firewalls, and backup systems to help keep your information private and secure. You are consenting for me to record our sessions using this system.

- Recordings of our sessions will be transcribed and summarised by this HIPAA-compliant technology. This program doesn't store the recordings and client personal information. I may choose to keep the summarised notes as part of your confidential medical record. The program only keeps anonymized data to help improve the tool. As with any technology, there are certain risks and benefits, which I will list here:

- All technology contains a risk of confidential information being disclosed. You can ensure the security of our communications by only using trusted secure networks for psychotherapy sessions and having passwords to protect the device you use for psychotherapy. The program mitigates this risk by ensuring up-to-date technological security and storing the data with as little identifying information as possible.
- The system researchers will have access to your de-personalized transcripts (transcript content with removed names, emails, and other identifying information).

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- The system may contain unknown bias in the way it generates the session summary and presents clinical information. This risk is mitigated by your therapist's commitment to review and modify the note as needed using their clinical expertise.
- The technology allows the therapist to focus more of their attention on therapy.
- Removes the need for taking notes or trying to remember information during and after the session.
- The system reduces the therapist's workload and may help with compassion fatigue.
- The technology may provide additional clinical insights for the therapist which helps improve outcomes in the therapeutic process.

By signing this consent, you are agreeing to allow your therapist to use this software. If you would like to opt out or have any questions, please discuss this with your provider.

**PART III: HEALTH INSURANCE**

**YOUR INSURANCE COMPANY:** By using insurance, I am required to give a mental health disorder diagnosis that goes in your medical record. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during the session. Your insurance company will know the times and dates of services provided. They may request further information to authorize additional services regarding treatment.

**IMPORTANT:** Some psychiatric diagnoses are not eligible for reimbursement (ie: marriage/couples therapy). In the event of non-coverage or denial of payment, you will be responsible to pay for services provided by **Gathered Connections Counseling, PLLC** who also reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.

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**PART IV: CONSENT**

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with my therapist. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize my therapist from Gathered Connections Counseling to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Gathered Connections Counseling, PLLC**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Gathered Connections Counseling, PLLC** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Gathered Connections Counseling, PLLC to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Gathered Connections Counseling, PLLC** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

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