Informed Consent and Psychotherapy Services Agreement

Child Psychotherapy

Lilac City Counseling, Inc. is a private group practice providing psychological services to children, adolescents, adults, couples, and families. Welcome to our practice. This document contains important information about our professional services and office policies. It is very important that you read this document entirely and carefully, as you will be asked to sign this document indicating that you are both aware of and in agreement with its content. **When you sign the signature page, it will represent an agreement between you and Lilac City Counseling, Inc.**

**PSYCHOTHERAPY SERVICES:** Psychotherapy can be an effective way to address issues in your child’s life. At times, it can be uncomfortable as the process involves discussing difficult aspects of your child’s life. You and your child may experience uncomfortable feelings, such as anger, anxiety, sadness and frustration. You and your child might recall unpleasant life events or face unpleasant thoughts, and you might face making major life decisions. These are often a natural part of therapy, and although there are no guarantees of specific outcomes from therapy, most therapy ends in the resolution of the difficulties which brought you and your child to our office. Therapy involves a large commitment on your part and we encourage you to ask questions about treatment at any time.

To maintain our commitment in providing you and your child with quality treatment, we maintain our licensure requirements, including adhering to our code of ethics, and we regularly attend continuing education courses. You have the right to question the therapeutic process and to refuse any procedure or method at any time. We are always available to discuss your child’s treatment. You will be offered a copy of the Client Bill of Rights and the HIPPA notice. In addition, we have copies of these documents posted in our waiting room; please read these and feel free to ask any questions. If you have any questions about your child therapist’s knowledge, experience, credentials, skills or license, please ask your therapist to provide that information to you.

**APPOINTMENTS:** Our office is open Monday through Friday and all services are provided by appointment only. You can reach us at (603) 743-4004. We have a part time receptionist who answers the phone during her office hours. You can leave a voicemail for us if our receptionist is out, and we will get back to you as soon as possible.

Your initial appointment will be an evaluation session, in which we will collect information about your child’s background and current problem. We will determine with you if treatment is needed, and a treatment plan will be developed and agreed upon with you. During this evaluation stage, we encourage you to also evaluate your level of comfort with us and your opinion about whether you feel comfortable working with us. Should you feel that we are not the right therapist for you, we are happy to provide referrals to other mental health professionals.

**Cancellation/No-Show Policy:**

Consistent attendance at therapy appointments is an important contributor to the success of your treatment. We understand that occasionally situations arise that require a cancellation. However, when clients frequently cancel or fail to come to appointments it interrupts and/or interferes with the treatment process and it takes away treatment opportunities for other clients.

If you have to cancel an appointment, we **require that you give us 24-hr notice**, so that the reserved time can be used for emergencies or clients on the cancellation/wait list. Exceptions are for inclement weather or illness only. If you fail to come, or cancel with less than a 24-hour notice for three therapy appointments, you may be discharged from psychotherapy services for a failure to participate meaningfully in treatment. If you repeatedly cancel with notice, your clinician may discuss with you your level of commitment to ongoing treatment.

**After Hours Coverage:**

We have a voice mail system which allows you to leave a message for your therapist when the office is closed. Non-emergency phone calls will be returned by the next business day or the next day your therapist is in the office. We also have 24-hr emergency phone/pager coverage. The emergency phone number is on the main outgoing phone message for the Lilac City Counseling office (not the individual clinicians’ mailbox messages). If there is an emergency, please call the emergency number and leave a voice message on that voice mail machine. The therapist on call will contact you by phone as soon as possible.

**PROFESSIONAL FEES:**

**Therapy services:** Our fee for an initial evaluation session is $160.00. Our fee for an hour therapy session is $150.00 and for a 45-minute therapy session is $130.00. **We accept payment by CASH and CHECKS only.** Payment of copays and deductibles are expected at date of service.

**Reports:** Our fee for other professional services, such as billing records, report writing, preparation of records or treatment summaries to any outside person or agency (except another mental health provider) and telephone calls for legal or disability issues which exceed 10 minutes will be charged on a prorated basis of $150.00 per hour. Payment will be required before the release of reports, letters, and/or treatment summaries.

**Legal:** We do not provide forensic services. Our primary objective is to provide therapeutic services. Our role is not to assess fitness for custody, to serve as an advocate or to act as an expert witness. If in the course of providing these therapeutic services, our professional services are also requested in legal matters, our fee is $200.00 per hour. In the event that we are asked or subpoenaed to testify in court, we will bill the party issuing the subpoena (or request to testify) for time needed to prepare testimony; for expenses to consult our own attorneys (if needed); and since time needed to testify in court proceedings is often unpredictable (at least half a day), your therapist will need to clear at least a half a day from their schedule to go to court. Payment of an estimated fee will be required prior to the actual court appearance.

**Cancellations: You will be charged $75.00 if you do not cancel with a 24-hr notice.** This fee is your responsibility; you will be asked to pay this fee before another session will be scheduled. Any additional appointments that have been booked in advance will also be cancelled until you have contacted your clinician and made arrangements to pay the $75.00 no-show/late cancellation fee.

**Returned Checks:** Returned checks will be subject to a $40.00 service fee.

**Responsibility for Fees:** If a divorce of legal separation has occurred, the parent scheduling and bringing a minor child for services has the responsibility for payment of our fees regardless of your legal stipulations.

**INSURANCE AND BILLING:** If you have insurance, we complete and process your claim for services for you. It is your responsibility to know whether you are required to have prior authorizations for services. It is also your responsibility to learn about your deductible, co-payment, and co-insurance amounts. Payment for deductibles, co-payments, and co-insurances is expected at the time the services are rendered. All fees are your responsibility regardless of your insurance status from the date services are provided. Our staff will be happy to answer questions related to insurance billing.

If you are covered by more than one insurance, you must inform us of all the insurances under which you are covered, since there are rules about which insurances must be considered primary and which must be considered secondary and our clinicians do not participate with all insurances.

Please let us know immediately if there are any changes to your insurance coverage.

**COLLECTIONS:** We use reminders, letters, and phone calls as part of our collection procedures. If unpaid balances are over three (3) months old, suspension of services will occur until payment is made in full. We understand that temporary financial problems may affect timely payment of your account. Please inform your clinician of any financial issues and we will work out an agreement with you.

**ETHICS, CONFIDENTIALITY AND CONSULTATION:** As licensed Psychologists and Clinical Social Workers, we uphold the principles of the American Psychological Association’s Ethical Principles of Psychologists and the National Association of Social Worker’s code of Ethics. Copies of these ethics are available in the waiting room. Under these ethics, all professional therapists must maintain professional boundaries with current and past clients at all times. Therapists should not socialize or become friends with clients and sexual contact between a therapist and a client is unethical and subject to disciplinary action. In case of therapist misconduct, please notify the New Hampshire Board of Psychologists, 112 South Fruit Street, Concord, NH 03301 or the New Hampshire Board of Mental Health Practice, 117 Pleasant Street, Concord, NH 03301.

Under New Hampshire statute, all communication between a therapist and a client is privileged and confidential. However, there are conditions when disclosure of privileged communications to the proper authorities is required. These conditions include: a) when there is abuse or neglect (physical, emotional and/or sexual) of children or an incapacitated adult, b) when a person is a danger to himself, c) when a person is a danger to another person – if a threat is made, the individual in danger and/or the police department must be notified, d) when a person makes threats against real property, and e) when a judge issues a specific court order for records.

NH law allows parents to have knowledge of the issues discussed in their child’s psychotherapy. However, in order for psychotherapy to be most effective, we encourage parents/guardians to allow the clinical information your child discusses to be kept confidential. If your child’s therapist believes your child is in imminent danger, you will be informed immediately and confidentiality will not be maintained.

As professional therapists, we are required to meet regularly with other therapists for professional consultation. We meet weekly to consult on treatment cases and we ask your permission to discuss your child’s case anonymously to plan and address treatment needs. All identifying information is omitted during these discussions to protect your child’s privacy. If you object to our consulting with each other about your child’s situation, please inform us, so that we can understand your concerns and work with you to best protect your child’s privacy.

If you use a managed care insurance, disclosure of treatment information is required by your insurance to secure coverage. For all insurance billing, we are required to send insurance information electronically. We can’t guarantee the confidentiality of such communications once it leaves our office. If you do not want information sent electronically, please inform us at the beginning of treatment, so we can determine how best to proceed with your billing. We employ administrative staff who have access to information for scheduling and billing; all staff are trained to protect your confidentiality and will not release any information at any time outside the practice. The professional staff are committed to the ethical principles of confidentiality, and no material will be communicated without your knowledge and your written permission except in the above noted conditions and those outlined by the HIPPA form you will receive upon intake.

**SOCIAL MEDIA:** We do not communicate with or contact any clients through social media platforms like Facebook, Twitter or Instagram. To do so would blur the boundaries of the therapeutic relationship. Some of our therapists might participate in various social networks, but not in their professional capacity – please do not try to contact us in this way. We have a website that outlines information about our professional experiences and specialties; please feel free to access our website at lilaccitycounseling.com for that information. In addition, we will not use any web searches to gather information about you or your child without your request as this violates your privacy rights.

**EMAIL/TEXT MESSAGES**: Each of our therapists have different policies regarding the use of email and/or text messages. If you would like to use email or text messages for non-clinical communication (scheduling or billing issues), please discuss that request with your child’s therapist. You will be required to sign a separate waiver allowing your child’s therapist to send information via email and/or text message. Email and text messages are not guaranteed to be a secure form of communication; therefore, we strongly discourage your use of it for any clinical discussion. If you do use email and/or text, do not include any personal identifying information such as your child’s birthdate or medical information. If you do use email or text messages and send clinical content, a copy of that email or text message will be printed and included in your child’s client record.

**COODINATION OF TREATMENT**: New Hampshire statute requires us to notify you of the following: to determine whether there may be a physical cause to your child’s mental health condition, we ask you to consider your child having a physical examination if one hasn’t been had in the last 6 months. If your child’s physician indicates that there is a physical cause, we are required to consult quarterly with the physician regarding treatment progress. Your permission to release information to the physician will be obtained under this condition.

**PROFESSIONAL RECORDS**: We are required to keep records of the psychological services provided to your child. This includes intake, diagnosis, treatment notes, insurance and billing information. You are entitled to receive a copy of your child’s records unless your child’s therapist determines that releasing the records would be likely to cause harm or injury to the child. We require both parents/guardian signature prior to releasing the records. Due to the nature of therapy notes, sometimes psychological records can be distressing to untrained readers. If you wish to see your child’s records, we strongly recommend that you review them together with your child’s therapist to discuss their contents. You will be charged a fee for any professional time used in response to information requests.

If we receive written request for your child’s records to be provided to a third party, you will be charged for the service of materials, copying and postage and any other costs associated with furnishing the record. Fees for records must be received prior to their release.

Parents/guardians should understand that information discussed in your child’s treatment sessions is for therapeutic process and is not intended for any legal proceedings; we strongly encourage you to not use your child’s records in legal proceedings, as they are rarely helpful to you in court.

**SIGNATURE PAGE**

**INFORMED CONSENT and AGREEMENT OF FINANCIAL RESPONSIBILITY**

**Your signature below indicates that you have read the information in this document and agree to the terms stated above.** You have read and understand the risks and benefits of psychotherapy, the ethics, confidentiality, consultation, and coordination of treatment requirements. You have read and understand the office policies on appointments, insurance use, email, social media and records. By signing this document, you understand that this represents an agreement between us and you give your consent to participate in treatment for your child.

I understand and agree that, regardless of my child’s insurance status, I am responsible for the full balance of my child’s account for any professional services provided. I certify that the insurance information provided is true and correct to the best of my knowledge. I will notify the office of any insurance information changes.

I have read, understand and agree to the office policies on fees, billing and collections. I understand the policy on cancellations and missed appointments and I understand and agree that I will be responsible for the $75.00 fee if I fail to provide 24-hour notice of cancellation.

**It is our policy to treat your child ONLY with the permission of both parents/guardians**. In cases of joint legal custody, if both parents/guardians can’t reach an agreement on therapy, it is the responsibility of the parents/guardians to resolve their differences through a court hearing BEFORE treatment will begin. If both parent/guardians do not provide signatures, a copy of the final divorce degree or any subsequent orders regarding medical treatment of your child must be provided before we can begin treatment. PLEASE BRING THIS DOCUMENT TO YOUR INITIAL SESSION

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Parent/Guardian #1 Signature Date

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**PRIVACY PRACTICE POLICY**

At the time of your child’s intake session, you will be offered copies of the HIPAA Privacy Policy and the NH Mental Health Bill of Rights. Please sign below ONLY AFTER you have been offered or have received copies.

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Parent/Guardian Signature Date

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Parent/Guardian Signature Date

**FOR THERAPIST USE ONLY**

I have reviewed this informed consent paperwork with my client and client’s parents/guardians and have answered any questions or concerns that my client and client’s parent/guardian has regarding this agreement.

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Therapist’s Signature Date