

Informed Consent for Therapy Services – Adult

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to our practice; WD Resource. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Page | 1

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I/WE, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks.

Risks may include:

1. Experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it.
2. Therapy often leads to a significant reduction in feelings of distress,
 - a. increased satisfaction in interpersonal relationships,
 - b. greater personal awareness and insight,
 - c. increased skills for managing stress and resolutions to specific problems.But, there are no guarantees about what will happen.
3. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss; outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I/WE will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me/us. If you have questions about our procedures, we should discuss them whenever they arise.

Informed Consent for Therapy Services – Adult

APPOINTMENTS:

Will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount on cancellation document [unless we both agree that you were unable to attend due to circumstances beyond your control].

Page | 2

PROFESSIONAL FEES

The standard fee for the initial intake is \$60.00 and each subsequent session (unless specific financial arrangements have been agreed to, as per sponsoring party). You are responsible for paying at the time of your session. Payment must be made by credit card, Health Savings Plan, or cash.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled “Limits of Confidentiality. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child’s agreement, unless I feel there is a safety concern, in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

Informed Consent for Therapy Services – Adult

CONTACTING ME/US

I/WE am often not immediately available by telephone. I/WE do not answer my phone when I/we are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from us or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe,

Page | 3

- 1) [Einstein Crisis Response Center](#)-One Penn Boulevard, 3rd Floor – Center Tower · (215) 951-8300
- 2) MossRehab Marvin Werman Outpatient Center : Einstein Mental and Behavioral Health 5501 Old York Rd · (215) 456-9850
- 3) [Friends Hospital Crisis Response Center](#)-4641 Roosevelt Boulevard. Philadelphia, PA 19124. 215-831-2600
- 4) [Mercy Hospital Crisis Response Center \(West Philadelphia\)](#) 5401 Cedar Avenue Philadelphia, PA 19143, 215-748-952
- 5) [Temple University/Episcopal Crisis Response Center \(North Philadelphia\)](#) 100 East Lehigh Avenue. Philadelphia, PA 19125. 215-707-2577

Go to your Local Hospital Emergency Room, or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me/us so that I/we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I/we refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Date _____

Description of Personal Representative's Authority: