

# Informed Consent

---

## Consent for Treatment

I, the undersigned, do voluntarily consent to psychiatric/behavioral health assessment and/or treatment for myself.

By signing below, I authorize ZOE Therapy Services to provide psychiatric and/or behavioral health assessment and exams, treatment, and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand that the purpose, potential risks and benefits, and alternatives to any treatment, as well as the risks of not having treatment, will be explained to me upon my request, and that I can always decline treatment.

I understand that while my treatment will be designed to help me, there is no guarantee of a successful outcome.

Psychotherapy involves risks, such as but not limited to, the development or worsening of emotions such as anxiety, sadness and anger. I understand that this is a normal response to working through life experiences and that these reactions should be discussed with my therapist or physician.

Treatment with Medication also has certain risks, varying with the type of medication prescribed, which will be explained to me. I know that taking a medication of any kind always carries the risk of a potentially fatal allergic reaction. I understand that it is my responsibility to make my physician aware of any health conditions that I have or that develop over the course of treatment, and to make my physician aware of any other medications, including over-the-counter medications or herbal supplements that I am taking. I also understand that discontinuation of medication should be discussed in advance with my physician.

I understand that it is my responsibility to inform my physician or therapist if I feel worse in response to any treatment provided, including but not limited to, the development or worsening of suicidal ideation, depression, agitation, anxiety, insomnia, irritability or mania, especially if these reactions are new, severe, or abrupt in onset.

I understand that as part of my mental health care, ZOE Therapy Services originated and will maintain electronic records describing treatment, testing results and forms, correspondence and insurance information. Except when required by law, this information cannot be disclosed without my written consent. I may revoke any authorization for disclosure at any time except if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

I further understand that I may request a complete copy of ZOE Therapy Services Privacy Practices at any time.

I understand that my treating clinician is required by law to maintain privacy of my mental health record and to provide me with notice of their legal duties and privacy practices with respect to my mental health record. The treating clinician has the right to change those privacy policies and practices with notification to you in writing.

I understand that at no time, am I permitted to record video and/or audio of my sessions with my treating clinician.

I understand that I have the right to disagree with decision made and I can make a formal complaint to a ZOE Therapy Services Privacy Officer/ Sarah Chamberlain at (804) 30.9622. A written complaint can be made to the Secretary of the U.S. Department of Health and Human Services.

I understand that this notice is in effect beginning January 1, 2018. If there are any changes to this notice while I am still in treatment at ZOE Therapy Services then I will be notified in person and writing about such changes. I acknowledge that I have been notified of the HIPAA policy and may request a complete written copy at any time.

## **Appointments**

Appointments will ordinarily be 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, you will be required to pay \$75 for the session [unless we both agree that you were unable to attend due to circumstances beyond your control].** It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancellation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

## **Confidentiality and Group Therapy**

Your Clinician will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your Clinician also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

## **Confidentiality and Technology**

Some clients may choose to use technology in place of or as an adjunct to their counseling sessions. This includes but is not limited to online counseling, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your Clinician will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who

may have access to your computer, phone or other technology used in your counseling sessions. Should you have concerns about the safety of your email, your Clinician can arrange to encrypt email communication with you.

## **Social Media**

Your Clinician does not accept friend or contact requests from current or former clients on any social networking site out of respect for your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

It is NOT a regular part of your Clinician's practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If your Clinician has a reason to suspect that you are in danger and you have not been in touch with him/her via usual means there might be an instance in which using a search engine becomes necessary as part of ensuring your welfare. If your Clinician ever resorts to such means, he/she will fully document it and discuss it with you at the next opportunity.

You will never be asked for a testimonial, rating or endorsement for any reason. Due to confidentiality, your Clinician cannot respond to any reviews, positive or negative, online.

## **Record Keeping**

Your Clinician will keep records of your in-person or tele-counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on an encrypted remote server or in a paper file and stored in a locked cabinet in the Clinician's office.

## **Professional Fees**

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by charge, check or cash. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required.

Fees are non-negotiable. To receive sliding scale fees, you must present proof of income through recent pay stubs or tax forms. Fees are subject to change at Clinician's discretion

## **Fee Schedule**

### Therapy Services

Psychiatric diagnostic evaluation (Intake) – \$150

Psychotherapy 45 minutes – \$90

Psychotherapy 60 minutes – \$135

Family psychotherapy – \$135

### Medication Management Services

Medication Management Evaluation (60min) - \$275

Medication Management Follow-Up (30min) - \$140

Medication Management Follow-Up (45min) - \$195

Medication Management Follow-Up (60min) - \$225

### **Services Not Covered by Insurance**

#### Neurofeedback Services

Brain Mapping - \$500

Neurofeedback 60min. Session - \$75

Neurofeedback 45min. Session - \$65

11 session package - \$750, 11 sessions for the cost of 10

Court appearance and Testimony – If any provider is subpoenaed for court, the fee is \$1200.00 for up to 4 hours. Beyond 4 hours but not greater than 8 is billed at \$2500.00. This fee includes preparation time, travel, waiting, testifying, etc. Additional fees may be assessed if travel out of the immediate area is required. Payment in full is required 5 business days in advanced of the the scheduled hearing. This fee continues to apply if your provider attends court and is not called to testify. Also if court is cancelled, continued, or rescheduled less than 3 business days prior to the court appearance for any reason (e.g. snow, the case being settled out of court, the judge cancelling the day, etc.).

Correspondence (Letters) or Reports -\$65 (or the discretion of your provider)

Copy of Records - \$35

There will be a charge of \$50.00 for any check returned by the bank.

### **Contacting Me**

Your Clinician is often not immediately available by telephone. At these times, you may leave a message on our confidential voice mail and your call will be returned within 24 hours for non-urgent matters. The most effective way to contact your provider is through your patient portal. Non-emergency phone calls, texts or emails requiring more than 5 minutes of Clinician's time will be scheduled as a Telehealth appointment.

**If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911.** Non-emergency phone calls, texts or emails requiring more than 5 minutes of Clinician's time will be scheduled as a Telehealth appointment.

## **Email**

Clinician may request client's email address. Client has the right to refuse to divulge email address. Email, computers, texts, and e-fax may not be completely secure and confidential. **Zoe Therapy Services ensures that all devices used are equipped with a firewall, virus protection and passwords.**

When phone, email or text is used as an adjunct to therapy, please be informed that all correspondence will become part of the medical record.

Clinician may use email addresses to periodically check in with clients who have ended therapy suddenly. Clinician may also use email addresses to send newsletters with valuable therapeutic information such as tips for depression or relaxation techniques. Clinician may have a blog and if this is appropriate for the client, Clinician may send information through email about subscribing to the blog or information related to mental health and wellness.