Peg Marland Counseling and Psychotherapy :

Individual Counseling/Psychotherapy Informed Consent and Agreement

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us. You must sign the document in two places: one relating to your agreement to participate in and your understanding of Individual Psychotherapy and one relating to confidentiality, business policies and intake information. It is important for you to know that I welcome all your questions.

Please do not sign this document if you do not understand any of its content.

INFORMED CONSENT AND AGREEMENT

I, (print your name)_____
understand and agree that Counseling/Psychotherapy is a process where mental health distresses and disorders are assessed, evaluated, and treated. It varies depending on the personalities of the therapist and patient, and the particular problems I bring forward. There are many different methods Therapists may use to deal with the problems that I hope to address. Counseling/Psychotherapy is not like some other health care visits or encounters where I do not play an active role. Instead, Counseling/Psychotherapy calls for a very active effort on my part. In order for the therapy to be most successful, I will have to work on the things we talk about both during our sessions and at home. I fully acknowledge that any benefit from psychotherapy is directly dependent upon my participation and my progression through therapy, but I fully acknowledge there is no guarantee or success rate that can be predicted in Counseling/Psychotherapy.

Counseling/Psychotherapy can have benefits and risks. Since Counseling/Psychotherapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, Counseling/Psychotherapy has also been shown to have benefits for people who go through it. Counseling/Psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are, however, no guarantees of what I will experience or accomplish.

My initial individual meeting with Peg Marland will involve an evaluation of my apparent needs, as well as my previous experience inCounseling/Psychotherapy. I understand that Counseling/Psychotherapy involves a large commitment of time, money and energy and that I need to be very careful about the Counselor that I select. I understand that if I have any concerns or questions about Peg Marland's therapeutic procedures, business policies or how confidential matters

are dealt with, that it is my obligation to bring these concerns or questions to Peg Marland's attention and that I can do so at any time. **I understand that if I have further doubt about the Counseling/Psychotherapy that I am receiving from Peg Marland, that she will be happy to help me set up a meeting with another mental health professional, who might better meet my needs.**

I have been informed of and agree to the additional confidential and financial provisions discussed in Peg Marland's **Confidentiality, Business Policies and Intake Information form.** I have been informed and provided with a copy of the **Health Insurance Portability and Accountability Act (HIPAA).**

Signature_____

Date_____

Relationship to Client_____

Peg Marland Counseling and Psychotherapy
Confidentiality, Business Policies, and Intake Information

Confidentiality

I place a high value on the confidentiality of the information that my clients share with me. The following information was prepared to clarify my legal and ethical responsibilities regarding this important issue.

Release of Information to Others

If for some reason there is a need to share information in your record with someone outside of my office (e.g. your physician, your insurance company or another therapist) you will first be consulted and asked to sign a form authorizing transfer of the information. Because of the sensitive nature of the information contained in some records you may wish to discuss the release of this material and related implications very carefully before you sign. Any form that I provide will specify the information you give me permission to release to the other party and will specify the time period during which the information may be released. You can revoke your permission at any time by simply giving me a written notice. It is important to understand that I cannot guarantee the continued privacy of your information once released to any other party including your insurance company.

As a part of my commitment to quality therapy I may decide it necessary to seek professional consultation with a colleague. Your identity will remain confidential in this situation.

Exceptions to Confidentiality

There are several important instances when confidential information may be released to others. First, if you have been referred to this practice by the Court ("court ordered"), you can assume that the Court wishes to receive some type of report or evaluation. You should discuss with me exactly what information may be included in a report to the Court BEFORE you disclose any confidential material. In such instances, you have a right to tell me only what you want me to know.

Second, if you are or become involved in litigation of any kind and inform the Court of the services that you receive from me (thereby making your mental health an issue before the Court), you may be waiving your right to keep your records confidential. You may wish to consult your attorney regarding such matters before you disclose that you have received treatment.

Third, if you threaten harm either to yourself or someone else, and I believe your threat to be serious, I am obligated under the law to take whatever actions seem necessary to protect you, or others, from harm. This may include divulging

confidential information to others and would only be done under unusual circumstances where someone's life appeared to be in danger.

Fourth, if I have reason to believe that you are abusing or neglecting your children or an elderly person in your care, I am obligated by law to report this to the appropriates state agency. The law is designed to protect children and the elderly from harm and the obligations to report suspected child/elderly abuse are very clear in this regard.

In addition, there may be some other rare instances in which you waive your rights to have your records protected. If you are involved in any type of current or potential legal difficulties that you discuss such matters with your attorney before informing others of the services you have received. Here I make every reasonable effort to safeguard the personal information, which you may share with me. There are, however, certain instances when I may be required by law to release such information to others. If you have any questions about confidentiality, please discuss them with me.

Business Policies

To make the best use of your time and mine, I strongly recommend weekly appointments, but require no less than an appointment every other week. If you are in therapy with anyone else at this time, please let me know.

I work on a pay-as-you-go basis. For purposes of efficiency, I would appreciate being paid at the beginning of each session. You will be charged the same amount for a session whether or not we use the full 50 minutes.

I do NOT accept direct payment from insurance or managed care companies. You pay me for each session and your company reimburses you to the extent of your coverage. I will provide you with receipts or statements upon request.

Business hours are 9:30AM-7:30PM Monday through Thursday and 11:00AM-4:00PM on Friday. The telephone answering machine is always on, so you may call to leave a message at any time. If your situation is urgent, you must indicate that in your message. I am available for brief telephone consultation during the week. However, if telephone time exceeds 15 minutes, I will charge you for that time.

PLEASE REMEMBER THAT REGARDLESS OF CIRCUMSTANCES, 24 HOURS NOTICE IS REQUIRED FOR CANCELLATION OF A SESSION OR YOU WILL BE CHARGED FOR THE TIME RESERVED FOR YOUR USE AT YOUR USUAL RATE.

I encourage you to share any reactions that you have to me personally and professionally so that our relationship can be kept clear.

Your signature below indicates you have read, understood, and agree to the Confidentiality and Business Policies of my practice.

Signature_____Date_____

Signature of a parent or legal guardian is required if you are under 18 years of age.

Signature_____ Date_____

Relationship to minor_____

Intake Information

Name:_____D.O.B:_____

Address:_____

City, State, Zip:_____Email:_____

Home Phone:_____Work Phone:_____Cell Phone:_____
(specify what phone number you prefer I call when returning yours. Thank you.)

Referred By:_____

***Notify in case of emergency*:**

Name:_____Phone:_____

Status of Physical Health:_____

_____

_____

Use of Medication:_____

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Previous Therapy and Dates:_____

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