

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document to provide your electronic signature(or sign in person).

The Therapeutic Process

Risks and Benefits

You have taken a very positive step by deciding to seek therapy. The benefits of therapy can include: a higher level of functional coping, solutions to specific problems, new insights into self, more effective means of communicating in relationships, symptomatic relief, and improved self-esteem. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events, becoming aware of feelings attached to those events, reflecting on difficult aspects of yourself or your life can bring on strong feelings of anger, depression, anxiety, guilt and frustration. There are no miracle cures, and there may be times that your symptoms could become worse during the course of your therapy. I cannot promise that your behavior or circumstance will change. I will seek to support you and do my very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself.

Course of Treatment Your participation in therapy is voluntary and collaborative. You and I will work together to determine the course of treatment, goals and treatment techniques that will be utilized. In most cases, I will be completing a diagnosis for the purposes of clarifying what we will work on as well as for insurance purposes. If you would like to discuss your diagnosis or have any questions or concerns please ask me directly. We will also be completing a treatment plan as a collaborative process based on the goals we identify together in your initial assessment and that information you provide in your intake questionnaire. You have the right to refuse any therapy technique, and at your request I can provide you with alternatives, which may include referrals to other forms of assistance outside of psychotherapy. Length of treatment will vary and will be determined by you and I collaboratively. Each individual has unique strengths and weaknesses, and each problem is different from the next. The goal is that each client will finish therapy in a timely manner, without unnecessary waste of time or money. If at any point during therapy I assess that I am not effective in helping you reach the therapeutic goals, I am obligated to discuss it with you and if appropriate, to terminate treatment.

Termination

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used, if you are in default on payment, or if I perceive any threats. You also have the right to terminate at any point and for any reason. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule a follow up appointment, or if you no show and do not contact me, for legal and ethical reasons, I must consider the professional relationship discontinued.

Insurance/Third Party Payers

If you will be using insurance it is your responsibility to verify your coverage, including any co-pays or deductibles. If your insurance does not cover your visits, or they apply the amount to your deductible, you will receive a bill and will be responsible for the full amount. Please talk with the Office Manager if you have any questions about your insurance coverage.

By signing this document you authorize the release of any medical or other information about you necessary to process claims or receive payment for services rendered by your therapist. This release includes any insurance carrier, third party payer or Vocational Rehabilitation. You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and I have no control over what they do with it once it is in their possession. I will provide you with a copy of any records I submit, if you request it. You understand that, by using your insurance, you authorize me to release such information to your insurance company. I will try to keep that information limited to the minimum necessary. You also authorize payment of medical benefits to the Ogden Center for Change, LLC for services rendered by your therapist.

Payments and Co-Payments

The cost for your therapy services will be as follows: for David Johnson, PhD \$200 per session, for Kathryn Johnson, LCSW \$150 per session, for Kevin White, CMHC \$150 per session, for Barrett Wilson, LMFT \$150 per session. If you are paying privately this whole cost will be your responsibility, if you are utilizing insurance you will be responsible for your portion (co-pay, deductible, etc). Payment for services is due on the date of service. If you choose to enter your credit card into your online portal using Stripe, your payment will be processed automatically following each weekly appointment (this includes any late cancellation or no show fees). If at any time you wish to remove your credit card information, log into your portal or talk with our

Office Manager and she will be happy to remove your information. If you would like a receipt emailed to you following each transaction please talk with our Office Manager. If your account has a balance on it due to non-payment we ask that you pay your bill in full before your next appointment. If you are unable to remain current on your bill, we will begin the termination process and offer you appropriate referrals.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client (or a minor's parent/legal guardian) requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. Additional, rare instances where disclosure is required or allowed by federal or state law.

In keeping with standards of practice, I may consult with other mental health professionals regarding care and management of cases. The purpose of this consultation is to ensure quality of care. These professionals are held to the same standard of confidentiality. I will maintain confidentiality and protect your identity by not using real names or any identifying information.

Ogden Center for Change maintains an electronic medical record system. Besides your therapist, your records are available to the Practice Administrator for scheduling, billing and oversight activities only. The Practice Administrator is subject to the same confidentiality requirements as your therapist.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Couples Counseling

By signing this document you agree and understand that information discussed in couples therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving the partners. You agree not to subpoena your therapist to testify for or against either party or to provide records in a court action.

By signing this document both members of the couple agree that anything either member tells the therapist, whether on the phone or in an individual meeting, may not be held as confidential, and at the therapist's discretion may be shared with the spouse/partner during a subsequent couple session.

When you attend couples therapy sessions, you as a couple are considered to be "the client" and your mental health records therefore belong to both of you. This means that except in the circumstances above, I will need a written consent from both of you in order to disclose any information from your record to a third party or to each individual member of the couple.

If you are participating in both individual and couples therapy at the Ogden Center for Change, both of your therapists will have access to your records and may consult on your case in order to ensure the best possible care. If there is any information that you do not want your therapists to discuss or if you would like to request that they not consult, it is your responsibility to communicate this with your therapists and request that your records be maintained separately.

Communication

You may opt into text or email reminders of your appointments through our client portal. Please be advised that our system does not allow for text or email responses to cancel or change appointments. I will not have the ability to text with you through our phone system.

Email is not a fully secure way to communicate. In an effort to protect your Protected Health Information it is our policy to keep email communications to a minimum. You may indicate whether email is acceptable to you in your client portal. You may desire to send an email in an effort to coordinate scheduling or communicate about billing or insurance issues. There are some potential risks to email which include email accounts can be hacked, misdelivery of email to an incorrect address, and the fact that email providers have access to the information contained in the email. We do use a professional service through google called G suite in order to enhance safety and security, but if you do choose to email please be aware of these risks. Ogden Center for Change maintains one general staff email that is monitored by the team, this is not intended for confidential communication with your therapist.

If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. If a true emergency situation arises, please call 911, or a local crisis line (801) 625-3700, or The National Suicide Hotline 1-800-273-TALK, or go to any local emergency room (e.g. McKay Dee hospital).

Recording sessions

Please feel free to take notes in session if you believe it will be helpful in remembering key points of discussion. However, audio or video recording of sessions is prohibited, unless express permission is given by your therapist.

Emotional Support Animals

If you are interested in obtaining an Emotional Support Animal letter, please be aware that I do not write these letters.

Teletherapy Informed Consent

I hereby consent to engage in teletherapy with a mental health professional through the office of Ogden Center for Change. I understand that

“teletherapy” includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical and psychological information – both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy, as such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality which are discussed in detail in Ogden Center for Change’s general Informed Consent for Psychotherapy I received along with this consent form. I also agree to not record teletherapy sessions without permission.
3. I understand that there are risks and consequences from teletherapy including, but not limited to, the possibility, despite reasonable efforts on the part of my clinician that the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons
4. In addition, I understand that teletherapy based services and care may not be as complete as and may have different risks than face-to-face services. I also understand that if my clinician believes I would be better served by another form of therapeutic services (e.g., face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the effort of my clinician, my condition may not improve and, in some cases, may even get worse.

5. While research has generally been supportive of telehealth for the treatment of a variety of individual diagnoses, there is little research to date on the effectiveness of telehealth for couple- or family-based services, and as such, these services are best categorized as experimental in nature.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I accept that teletherapy does not provide emergency services. During our initial session, my clinician and I will discuss an emergency response plan, which may include identifying my support system and emergency contacts that I have access to and will allow my therapist to have access to in the case of emergencies. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency department for help. I can also contact Ogden Regional Hospital at 801-479-2111 or McKay Dee Hospital at 801-387-7000. If I am having suicidal thoughts or making plans to harm myself, I can also call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24 hour hotline support.
8. I understand that I am responsible for (1) – providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) - the information security on my computer, and (3) – arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions. I understand that it is important to use a secure internet connection rather than free/public wifi.
9. I understand that while email may be used to communicate with my clinician, confidentiality of emails cannot be guaranteed. I also understand that clinical information will not be discussed over email.
10. Should you attempt to reach me between scheduled telehealth sessions, please allow up to 24 hours for a response, as I may be busy with other clients.
11. I understand that the backup plan for teletherapy if there is a disruption in connection includes contacting my therapist at 801-781-5733 or my therapist contacting me at the number provided in my demographic information.
12. I understand that it is my responsibility to ensure that my insurance company covers teletherapy, and if they do not I am responsible for the full cost of the sessions.
13. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law(s).
14. I understand that my clinician uses a HIPAA compliant software called Simple Practice and that my clinician will send me a link to the software should I decide I want the option of having sessions via the teletherapy.
15. I understand that my clinician will conduct my teletherapy sessions from a location where that clinician is also a licensed mental health professional. I understand that I am able to connect via smart phone, tablet, or computer/laptop from anywhere I have an internet connection.

PLEASE NOTE: Due to State Licensing Laws for mental health professionals, I agree to only participate in Teletherapy if I am within Utah at the time of my therapy appointment.