INFORMED CONSENT

Welcome to Whole Self Therapy! I appreciate your giving me the opportunity to work with you. This packet answers questions common questions about therapy. I believe my work will be most helpful to you when you have a clear idea of what to expect from therapy. Please do not hesitate to ask me any questions you may have regarding this packet.

About Therapy

Therapy is a collaborative partnership between you and your therapist. My goal is to create a safe environment necessary for exploration, understanding, healing and growth. Therapy requires your active participation. From time to time, you and I will evaluate your progress and goals. An important part of your therapy will be practicing new skills that you will learn in your sessions. I may assign "homework" like exercises, journaling, or reading to deepen your learning. You will probably have to work on relationships in your life and make long-term efforts to get the best results. These are important parts of personal change. Counseling may evoke feelings, memories and thoughts that are difficult or uncomfortable to experience. The specific goals, techniques and outcomes of counseling will be dependent upon the needs, abilities and motivation of each client.

Effects of Therapy

While benefits are expected from therapy, specific results are not guaranteed. Therapy is a personal exploration and may lead to changes in your life views and choices. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, sorrow, anxiety or pain.

As with any powerful treatment, there are some risks with therapy. For example, there is a risk that you will experience uncomfortable thoughts or feelings during the course of treatment. Also, clients in therapy may have problems with people they are in close relationships as dynamics may change throughout the course of therapy. Sometimes a client's problems may temporarily get worse before they get better. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that you may not get the results you were hoping for, and there are no guarantees of specific results. The success of our work depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy.

Cooperation of Client

You shall provide your therapist with any changes regarding address, phone number, contact information or business affiliation during the time period which your therapist's services are required. You shall comply with all reasonable requests of your therapist in connection with therapeutic treatment. Your therapist may, set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including without limitation: your refusal to comply with treatment recommendations, such as needing a higher level of care, your therapist is uncomfortable working with you or your failure to timely pay fees in accordance with the financial agreement, subject to the professional responsibility requirements to which your therapist is subject.

The following actions may lead to immediate termination of therapy services: arriving for a therapy session intoxicated or under the influence of an illegal substance, or threats of violence to staff.

Communication Between Sessions

My practice is not setup for crisis care. If you need immediate attention, please go to your nearest emergency room, call 911, or call one of the following hotlines: **the Suicide & Crisis Center of North Texas at 214-828-1000, 800-SUICIDE or 800-273-TALK**. Otherwise, you may contact me via phone or email. Please know that email and texting are not secure forms of communication and I cannot guarantee confidentiality. I do everything I can to safeguard the information and be HIPAA compliant, but breaches do happen. You may decide to contact me via text or email for clarification in scheduling or for minor issues, but it is important to know that I may not be able to respond quickly and that my responses will be brief to maintain confidentiality as best as possible. By signing the consent for treatment form, you acknowledge this risk. You may also opt out of receiving email in writing.

What to Expect from Our Relationship

As a professional, I will use my best knowledge and skills to help you. This includes following the standards of the Texas State Board of Social Workers (hereafter referred to as the SW Board). In your best interests, the SW Board puts limits on the relationship between a therapist and a client, and I will abide by these. It is important that you understand these limits, so you will not think they are personal responses to you.

First, I hold a license to practice social work, which includes psychotherapy, but not the fields of law, medicine, finance, or any other profession. I am not technically qualified to advise you from these other professional viewpoints. I am also a Somatic Experiencing practitioner. My work is influenced by several schools of psychotherapy and somatic practices (bodywork), all of which help people understand their bodies, injuries, emotional lives, relationships, illnesses and personal dynamics as part of their healing process. There are times that integrating psychotherapy and somatic therapy might be helpful. You have the choice of working exclusively in somatic therapy or exclusively in psychotherapy, or integrating them. Which model and modalities/interventions I employ will depend on your situation and will be done with your informed consent. Modalities/Interventions can include talk therapy, guided imagery and meditation, exercise, manual (hands-on) therapy, and Somatic Experiencing. All therapeutic work, including hands-on therapy, is strictly at a professional, not a personal level. You have the right to withdraw from therapy at any time.

Second, state laws and the rules of the SW Board require me to keep your information confidential. Limits to confidentiality are explained in the "Confidentiality and Notice of Privacy" section of this packet. If you encounter me in public or socially, I will not take the initiative to greet you. I will, of course, acknowledge you if you approach me first, but to protect your privacy I will do my best to remain oblivious to your presence in a concerted effort to maintain the confidentiality of your relationship.

Third, in your best interest, and following the SW Code of Ethics, I can only have a professional relationship with you. I cannot have any other role in your life. I can never have a social, sexual or romantic relationship with any client before, during, or after, the course of therapy. And I cannot have a business relationship with any of my clients, other than the therapy relationship. Bartering for services is not allowed.

Fourth, if you ever become involved in a divorce or custody dispute, please understand that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because of our therapeutic relationship; and (2) the testimony might affect that therapeutic relationship. If I am ordered to appear, you will be responsible for and shall pay the costs involved in producing the records and the hourly rate charged by your therapist at the time of the request or service of the subpoena (current rate is $300/hour) with a minimum of 4 hours billed for the time involved in traveling to and from the testimony location, travel expenses if testifying outside of DFW Metroplex, reviewing records and preparing to testify, waiting at the location and in giving testimony.

Video or Audio Recordings

You acknowledge and, by signing this information and consent form below, agree that neither you or your therapist will record any part of your sessions unless you and the therapist mutually agree in writing that the session may be recorded. You further acknowledge that your therapist objects to you recording any portion of your sessions without the therapist's written consent.

Grievances

As a social worker I am committed to upholding the rules and policies of the Texas SW Board. If you are not satisfied with me or your treatment, please raise your concerns with me immediately. I will make every effort to hear any complaints you have and to seek solutions collaboratively with you. If you feel that I have treated you unfairly or have been unethical, you may contact the SW Board directly at 1-800- 232-3162.

Social Media Policy

I will not accept friend or contact requests from any clients, past or present, on any social media site. I will not like, follow, or comment on your blogs or other postings on the Internet. This is to protect your confidentiality. I do maintain a business page on various social media sites, only to provide resources and updates about my practice. You may like or follow any of these pages, but this is not my expectation and I cannot request endorsements. You may view or share any of the content provided there, but please do not message or contact me via social media, as these communication platforms are not secure.

You may also find me on certain business review sites, like Yelp. It is unethical for counselors to solicit testimonials from their clients, so please do not misinterpret my listing as a request for ratings or reviews. That being said, you have every right to list a review on any platform you wish. It is very common that clients share information about their therapy, including the name or practice of their therapist, with people they trust. Many of my clients are referred to me in this manner.

Defamation

By signing this intake and consent form below you agree that you will not make defamatory comments about your therapist to others or to post defamatory commentary about your therapist on any website or social media site. In the event defamatory remarks about your therapist are made by you, or others acting in concert with you, you further consent by signing this intake and consent form below to allowing your therapist to use confidential information necessary to rebut or defend against, or prosecute claims for, the defamation.

Therapist's Incapacity or Death

You acknowledge that, in the event your therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of your file and records. By signing this information and consent form below, you give consent to allow another licensed mental health professional selected by your therapist to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice. Your therapist will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

Scheduling and Fees

My fee is $175 per 50 minute session.

Therapy appointments are scheduled weekly, especially in the beginning weeks of treatment. Sessions are scheduled with me directly. You must inform me of any cancellations at least 24 hours in advance by calling 972-591-3167 and leaving a voicemail or emailing sarah@wholeselftherapydallas.com.

Failure to cancel a session without 24 hours notice will result in a missed session fee of $50 per missed appointment. I keep the fee lower than the full session rate and apply it to all late cancellations to remove myself from determining acceptable reasons for a miss. Please note that this fee is not covered by insurance and is subject to change.

If you "no show" an appointment, or cancel with less than three hours notice, the full $175 charge will apply and will be billed to your card on file. I reserve your time for you and cannot use the time to make phone calls or start other work when I am sitting and waiting for you to arrive. Therefore, I must charge my full fee.

Please be on time for your appointments. Your session starts at the time scheduled and ends 50 minutes from that time. If you are late, please understand that I must end the session as scheduled so that I can start on time for the next client. Payment for services is an important part of any professional relationship. It shows that you value your healing and personal development. I accept cash, checks, and credit cards, and payments are due at the beginning of each session. I keep a credit card on file for most clients.

Insurance

If you are using health insurance to cover all or a portion of the cost of treatment, please know that insurance providers require a mental health diagnosis and that services be "medically necessary" to use your benefits. There are many reasons to come to therapy and not all could arguably be considered "medically necessary." Please consider this before deciding to use your insurance. In addition to requiring a diagnostic code, your insurance company is also provided with your service dates, and may inquire about your treatment progress as a matter of determining eligibility for payment. Insurance does not pay for missed appointments or late cancellations. At this time, I am not contracted with any insurance companies. If you are filing for out of network benefits with an insurance company I can provide you with a superbill to submit to your health plan for reimbursement.

CONFIDENTIALITY AND NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private.

_____ **How I use and disclose your protected health information with your consent**

I will use the information I collect about you mainly to provide you with treatment, to arrange payment for my services, and for some other business activities that are called, in the law, health care operations. HIPAA permits health care providers to disclose to other health providers any protected health information (PHI) contained in the medical record about an individual for treatment, case management, and coordination of care and, with few exceptions, treats mental health information the same as other health information. After you have read this notice and sign at the bottom, then this will let me use and share your information in these ways. If you do not consent and sign this form, I cannot treat you. If I want to use or send, share, or release your information for other purposes, I will discuss this with you and ask you to sign an authorization form to allow this.

_____ **Disclosing your health information without your consent**

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated or permitted by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of clients in treatment facilities, sexual exploitation; AIDS/HIV and other communicable disease infection with possible transmission; court orders, criminal prosecutions; child custody cases; suits in which the mental health of a party is an issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, protect, notify or disclose; sexual exploitation by a mental health professional or member of the clergy; fee disputes between the therapist and the client ; a negligence suit brought by the client against the therapist; the filing of a complaint with a licensing board or other state or federal regulatory authority; to regulatory authorities in connection with their compliance or investigatory responsibilities; to employees or agents of the practice for operational purposes, and for treatment consultations with other mental health professional when deemed necessary by the therapist.

_____ **Duty to warn and Emergency Contact**

In the event that your therapist reasonably believes that you are a danger, physically or emotionally, to yourself or another person, by signing this information and consent form below, you specifically consent for your therapist to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the following persons:

Please write your emergency contact name, relationship, and phone number below:

_____ **Your rights regarding your health information**

1. You can ask me to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask me to call you at home, and not at work, to schedule or cancel an appointment. I will try my best to do as you ask.
2. You can ask me to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information I have about you, such as your medical and billing records. You can get a copy of these records, but there is a $25 charge for it.
4. If you believe that the information in your records is incorrect or missing something important, you can ask me to make additions to your records to correct the situation.
5. You have the right to a copy of this notice. If I change this notice, I will post the new version in our waiting area, and you can always get a copy of it from me.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with Texas Attorney General at https://www.oag.state.tx.us/consumer/hipaa.shtml. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way. If you have any questions regarding this notice or my health information privacy policies, please do not hesitate to let me know. The effective date of this notice is 11/29/16.

_____ I have read and understood the above information regarding confidentiality and privacy.

CONSENT TO TREATMENT

_____ I have read and received a copy of the Informed Consent packet and have had the opportunity to discuss any of the information found therein with my therapist. I know that I can ask about any of this information at any time with my therapist throughout the course of treatment. I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy.

_____ I understand that no specific promises have been made to me about the results of treatment, the effectiveness of the procedures used, or the number of sessions necessary for therapy to be effective. I understand the benefits and risks of therapy.

_____ I understand the legal protection of my private records and personal health information, and also the limitations to confidentiality as outlined in the Informed Consent.

_____ I agree to act according to the points covered in the Informed Consent. I hereby agree to enter into therapy with this therapist (or to have the client enter therapy), and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ I agree to the cancellation policy and know that my card will be charged $50 if I cancel within 24 hours and the full fee if I cancel within 3 hours of the appointment or no show.

For Lyra clients, if your company does not cover late cancellations or you have exceeded the maximum they will cover, then you will be responsible yourself.

_____

Client/Parent or Guardian Signature and Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent. I agree to enter into therapy at this time with the client, as shown by my signature here. I have the right to discontinue therapy and provide referrals at any time if I feel it is clinically appropriate.

_____

Therapist Signature and Credentials

NEW CLIENT INTAKE Today's date: _____

Client's name: _____

Date of birth: _____ Age: _____ Gender: _____

Home street address: _____

City, State: _____ Zip: _____

Preferred phone: _____ e-mail: _____

May I email you at this address, leave voice mails at this number, or return texts from this number?

Email YES or NO Voicemail YES or NO Text YES or NO

Emergency Contact (name, relationship, phone number): _____

How did you hear about me?

❑ Google Search ❑ Psychology Today ❑ Social Media ❑ Friend/Family ❑ Other Professional: _____

What is your main concern at this time?

_____

_____

_____

How long has this been going on and what have your already tried to do about it?

_____

_____

_____

Have you been to counseling before?

❑ Yes ❑ No

Please check if you have experienced any of the following:

❑ Car Accident ❑ Fall from a distance ❑ Natural disasters ❑ Any near death experiences

❑ Surgery ❑ Major or prolonged medical issues ❑ Anything else you felt was traumatic

Please check any of the following issues you are currently struggling with:

□ Anger	□ Finances	□ Life Transitions	□ Sexual Issues
□ Anxiety	□ Gender identity	□ Marriage/relationships	□ Substance Abuse
□ Career/work	□ Grief/loss	□ Parenting/Fertility Issues	□ Trauma
□ Depression	□ Health	□ Self Esteem	□ Other: _____

List any medications you are taking, what they are for, and the prescribing physician's name.

List supports and resources that are available to you (family, friends, church, support group, etc.).

What do you consider to be your greatest strengths?

What would be different about your life if you no longer struggled with these issues?

Is there anything else you would like me to know about?

Video Therapy Informed Consent

Client Name: _____

Thank you for choosing to with with me, Sarah Reidy of Whole Self Therapy. Please read the following video therapy consent and sign below. If you have any questions, please let me know, and I would be happy to answer them.

1. I understand that I am about to engage in a video therapy session with my provider, Sarah Reidy.
2. I understand that the video conferencing technology will not be the same as an in-person session with a provider due to the fact that I will not be in the same room as my provider. I also understand that, in order to have the best results for this session, I should be in a quiet place with limited interruptions when I start the session.
3. I understand the potential risks to this technology, include interruptions, unauthorized access and technical difficulties. I understand that Sarah or I can discontinue the video therapy session if it is felt that the videoconferencing connections are not adequate for the situation.
4. Sarah agrees to inform me and obtain my consent if another person is present during the consultation, for any reason. I agree to inform Sarah if there is another person present during the session or if I wish to tape the session.
5. I understand that there are alternatives to a video therapy session available, including the option of finding another provider to see in-person if available in my area, which Sarah will be happy to help me find.
6. I understand that I can direct questions about this video therapy session at any time to Sarah.
7. I understand that this consent will last for the duration of the relationship with Sarah, including any additional video therapy sessions I may have; I can withdraw my consent for a video therapy session at any time, and Sarah will work with me to find a suitable alternative.
8. I understand that same confidentiality protections, limits to confidentiality, and rules around my records apply to a video therapy session as they would to an in-person session.
9. I agree to work with Sarah to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions.
10. I understand that Sarah may decide to terminate video therapy services, if she deems it inappropriate for me to continue therapy through video sessions. Sarah will work with me to identify another provider for in-person care.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I agree to participation in a video therapy session(s) with Sarah Reidy, LCSW, SEP.

_____

Client/Parent or Guardian Signature and Date