Informed Consent for Treatment

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INFORMED CONSENT FOR PSYCHOTHERAPY AND CONSULTATION

This Informed Consent document will provide a clear framework for our work together. Please read this entire document and indicate that you have reviewed this information and agree to it by signing at the end of the document. If you have any questions or need help understanding anything contained in this document, please contact our office using the phone number above.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. 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 and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

About the therapist

Braden Duncan, LCSW is licensed under the authority of the Arkansas Social Work Licensing Board (License #6975-C) as a Licensed Certified Social Worker. For more information about the board see http://www.accessarkansas.org/swlb. He holds a Master of Social Work (MSW) degree from University of Arkansas at Little Rock.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client 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.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

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.

For more details regarding privacy, refer to *Notice of Privacy Practices*.

Payment Schedule and Policies

If you are using insurance, Integrated Counseling Solutions will make effort to verify your insurance plan eligibility and benefits and communicate to you an estimate of your expected out-of-pocket costs before your appointment. This estimated amount, if any, will be due in full at the time of service. Integrated Counseling Solutions will then submit a claim to your insurance provider. Your insurance provider will review the claim and then, usually within 2-8 weeks, provide a final report of the amount they will cover and also the amount, if any, that you are responsible for according to your plan's policy. This report is sometimes called an Explanation of Benefits (EOB) and you can obtain a copy of this by contacting your insurance plan provider. If the reported amount you are finally responsible for is less than the amount you paid at the time of service, you will be refunded the difference. If your final responsibility is more than you paid at the time of service, you will be invoiced for the difference and this amount will be due within 30 days of that invoice. While Integrated Counseling Solutions will make effort to provide you an accurate estimate upfront you are still strongly encouraged to contact your insurance plan provider before your appointment to obtain your own estimate of copay/coinsurance/deductible amounts that you will be required to pay.

If you are not using insurance, your account will be considered "self-pay" and the full amount for your appointment will be due at the time of service. For current self-pay appointment rates, please contact Integrated Counseling Solutions.

All payments must be made using a debit/credit/health savings card. You will be asked for this card information at the time of scheduling. You will also be asked to sign a form authorizing Integrated Counseling Solutions to automatically charge this card for the full amount owed according to these policies (see *Credit/Debit Card Payment Consent)*. Once authorized, this charge will automatically take place within 24 hours of your appointment. Arrangement to use other methods of payment, including cash or check, may be made upon request.

No-Show or Late-Cancellation Fee

If you do not attend a scheduled appointment without canceling or rescheduling within 24 hours of your appointment time you will be charged a *$25 no-show/late-cancellation fee* to account for the time reserved. After three occurrences future scheduling must be approved by your provider.

Telehealth

Telehealth appointments (also known as video appointments or virtual visits) provide a convenient and private way for us to meet when we are unable to do so in-person. You may choose whether or not you are willing to use telehealth appointments. If you choose to use telehealth for any of your appointments the following terms apply to your signature at end of this document:

CONSENT FOR TELEHEALTH APPOINTMENT

1. I understand that my health care provider wishes me to engage in a telehealth consultation and that I have the right to accept or reject this method of service delivery.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that using telehealth for my appointment has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand that I must inform my provider at least 48 hours before my telehealth appointment if I plan to join the appointment from a location outside my state of residence. NOTE: healthcare providers must be authorized to practice in the state in which their client is physically located during their appointment. *Example: a client who lives in Arkansas is visiting their sister in Oklahoma for the week and plans to join their next telehealth appointment from their sister's home. Even though this client lives in Arkansas, their healthcare provider must still be authorized by the State of Oklahoma to complete this appointment.*
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation.
6. I have contacted my provider with any questions I have had about using telehealth appointments. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth appointments. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

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 ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I agree to the items contained in this document.

— IF YOU ARE COMPLETING THIS DOCUMENT ONLINE — CLICKING ON THE CHECKBOX BELOW CONSTITUTES MY SIGNATURE INDICATING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT AND THAT I AM THE CLIENT OR THE PARENT/LEGAL GUARDIAN OF THE CLIENT WHO IS SEEKING SERVICES.

— IF YOU ARE COMPLETING THIS DOCUMENT ON PAPER — BY SIGNING ON THE LINE BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT AND THAT I AM THE CLIENT OR THE PARENT/LEGAL GUARDIAN OF THE CLIENT WHO IS SEEKING SERVICES.

Signature _____

Date _____

In behalf of _____