Informed Consent for Treatment

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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 us.

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, help you clarify what it is that you want for yourself, and provide evidence-based treatment interventions.

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.

DURATION AND FREQUENCY OF TREATMENT

The standard meeting time for psychotherapy is 55 minutes. Shorter sessions are available on a case-by-case basis. Discuss your preferences with your therapist. Session fees are adjusted based on the length of a session.

The frequency and total number of sessions is determined on a case-by-case basis. Some therapy goals and objectives only require a few sessions while others benefit from a longer term plan that supports change and maintenance over many months. At the beginning of treatment you will be given a Good Faith Estimate (GFE) that details the number of sessions your therapist suggests. You or your therapist may suggest a change in your treatment at any time. Termination of therapy is an important part of the therapeutic process and can be earlier or later than expected depending on your needs. You are encouraged to discuss any questions you have about your therapy with your therapist frequently.

PAYMENT POLICIES

1) Your credit / debit / HSA card on file will be automatically charged for any balance you owe within 24 hours of invoicing, given that you sign the *Credit Card Payment Consent* form offered to you during the intake process. If you do not sign this authorization form payments are due within 14 days of invoicing.

Manual payments can be made online using the Client Portal.

Invoices are created at the time of service based on an estimate of the out-of-pocket cost your insurance company will expect you to pay. See below for how to obtain this estimate. If it is expected that your insurance will pay 100% (including and after any secondary or supplement insurance plan payments) then you will NOT be invoiced and your card will NOT be charged. After we file the claim for your session it can take a few weeks before your insurance company sends us an Explanation of Benefits (EOB) with their final decision of what they will pay and what they expect you to pay. If this EOB shows a different amount owed than what you already paid then you will be refunded or invoiced accordingly. If you are a self-pay client or your insurance benefits will not cover your sessions you will be invoiced at the time of service for the entire self-pay session fee as listed below. You will be notified by email when any new invoices have been created and are available to view and pay on the client portal. Unpaid invoices older than 14 days are considered "past due" and we will contact you for collection.

2) You are responsible to contact your insurance company to obtain an estimate of your expected out-of-pocket costs before your appointment.

To get an estimate of how much your insurance company will expect you to pay for a session call the customer service number on the back of your insurance card and ask what your expected out-of-pocket cost will be for “an outpatient mental health therapy visit” or “a counseling session”. Some insurance plans have a set fee you pay for each visit (copay). Others will pay a percentage of the visit only after you meet your deductible (coinsurance). And some plans won’t provide any coverage at all but will still apply the cost of the session to your deductible (deductible). If you have to meet your deductible first be sure to ask how much of your deductible is remaining so you know how much you will be required to pay before your coverage begins.

The maximum amount you could pay for a session if your insurance does not offer a discount and does not provide coverage is listed below under *Fees.* Most insurance plans, however, will offer you a discount on our standard rates so it is possible that your final responsibility will be less than the *Session Fees* listed below.

3) You must let us know before your first appointment if you are choosing not to use your insurance and to self-pay for your appointments instead.

Please be advised that if we don’t file claims with your insurance company then any amounts that you pay will not apply towards your insurance deductible.

If you are not using insurance then your account will be considered “self-pay” and the full self-pay session fee will be invoiced at the time of service. For current self-pay rates, please see Session *Fees* below.

4) Self-pay or uninsured clients will be given a Good Faith Estimate (GFE) at the beginning of treatment that details the expected total cost of treatment based on your therapist’s recommendations.

A Good Faith Estimate (GFE) is also available to insured clients upon request.

SESSION FEES

First Session:

$175 (self-pay $149)

Continuing Sessions:

53-60 min - $175 (self-pay $149)

38-52 min - $132 (self-pay $113)

16-37 min - $88 (self-pay $75)

NO-SHOW / LATE-CANCELLATION FEES

If you need to cancel or reschedule an appointment, please give at least 24 hours notice to avoid a fee.

If you do not attend a scheduled appointment you will be charged a **$35** no-show fee to account for the time reserved.

If you cancel or reschedule an appointment without giving at least 24 hours notice you will be charged a **$25** late-cancellation fee to account for the time reserved.

After three occurrences of no-show or late-cancellation future scheduling must be approved by your provider.

METHODS OF COMMUNICATING WITH US

To communicate with your therapist between appointments please use the secure messaging feature in the client portal. Look for the messaging icon. Watch your email for notifications that your therapist has responded. We cannot guarantee the security or privacy of any communication by email or text messaging. If you use email or text messaging please limit the content of your message to scheduling, billing, and other administrative concerns and reserve any therapeutic, sensitive, or private content for the client portal.

We may reach out to you about scheduling, billing or other administrative concerns using email or text messaging. Please let us know if you want us NOT to use email or text messaging to communicate with you about administrative concerns.

If you or a loved one are in crisis and need immediate support please contact the 988 Suicide & Crisis Lifeline by calling/texting 988 from any phone at any time. If you are experiencing a life threatening emergency, go to the nearest emergency room or dial 911.

TELEHEALTH

Telehealth appointments (also known as video appointments or virtual visits) are available. 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.

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*.

BY SIGNING THIS FORM I CERTIFY:

- That I am the client or the parent/legal guardian of the client who is seeking services.
- 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 the items contained in this document.

CLICKING ON THE CHECKBOX BELOW CONSTITUTES MY SIGNATURE.