Informed Consent for Treatment
Confidentiality and Consent to Use and Disclose Health Information

Client Name: ___________________________________ Parent/Legal Guardian: ____________________________

Client Address: ____

Treating Therapist: ___________________________ Supv. Therapist (if applicable) ____________________________

Santel & Kerr LLC is a group practice of independently contracted psychotherapists. Santel & Kerr LLC provides administrative services such as billing, scheduling, etc. Your psychotherapist, as listed above, is licensed by the State of Ohio Counselor, Social Worker, Marriage and Family Therapist Board (the Board) to engage in mental health assessment and psychotherapy, either independently or may require certain activities supervised by a licensed Supervisor. If your therapist requires supervision as mandated by the Board, the supervisors name is also listed above and your therapist can explain in detail the supervision requirements. The listed Supervisor will have full access to your confidential and protected information to assist in the training/supervision of your therapist. Additionally, case consultation is considered a best practice in mental health counseling/therapy and therefore, all psychotherapists affiliated with Santel & Kerr LLC will engage in regular case consultation. This consultation will be with other psychotherapists, including those with more experience and/or licensed as a Supervisor and will not include identifying information on any client. It is possible, however, within the case discussion that a client's identity could be discerned incidentally. All psychotherapists engaged in our case consultations have agreed to keep all client information strictly confidential.
*** Note: the words "psychotherapist", "counselor", and "therapist" are used interchangeably throughout this document.**

Mental Health treatment has risks and benefits associated with it, some of which are described below. Your (client and/or parent/legal guardian) signature(s) below indicates that you wish to receive this treatment and that you have had these risks and benefits explained to you.

Informed Consent for Treatment

1. The approach to counseling and psychotherapy will reflect the various evidenced based therapeutic modalities and is a collaborative effort between the therapist and client. By entering into this therapeutic relationship you are stating that you are prepared to attend scheduled appointments and partner in the counseling process. It is expected that you will make the commitment to attend scheduled appointments. You understand that the counseling time is valuable, and that my counselor is committed to working with you/your child. Repeated cancelations call into question your commitment to the therapeutic process and impede progress, and may result in the loss of regularly scheduled appointment times previously agreed upon.

2. You have the right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy on behalf of a minor client.

3. Your counselor uses a variety of communication to stay in contact including phone, text messaging, and email, if preferred. However, your therapist cannot be reached 24 hours a day and emergencies happen. If you are experiencing an emergency, you will contact Netcare in Franklin County at 614-276-CARE or dial 911 in or outside Franklin County, or Nationwide Children's Crisis Line if the client is under age 18 at 614-722-1800.

4. Your appointment time has been blocked off for you. You will make every effort to keep your scheduled appointment. If you are unable to keep your appointment, you know that it is expected to give 24 hour notice

directly to your treating therapist. You understand that if you do not keep your scheduled appointment that your commitment to treatment could come into question.

5. By signing this document you are stating that you understand that there are no guarantees as to the success of treatment. Treatment goals may not be achieved should you decide to discontinue treatment against the advice of you or your child's therapist, and/or continued cancelations.

6. You have the right to be informed in advance of the reason(s) for discontinuance for service provision, and to be involved in planning for the consequences of that event, the right to receive an explanation of the reasons for denial of service, and the right to know the cost of services.

7. You understand that you have the responsibility to provide accurate and complete information in order for treatment to be appropriate and effective, and for accurate assessment and evaluation to occur.

8. Your therapist may use several therapeutic techniques in counseling including, but not limited to, EMDR (Eye Movement Desensitization and Reprocessing), Ego State and Somatic Therapy, and Clinical Hypnotherapy. These techniques can be helpful in some situations with some clients. If determined by your therapist that the use of these techniques may be useful, information will be offered about these services and you will be provided opportunities to ask questions and obtain additional information to inform you of their potential risks and benefits. These techniques, and others, are offered as a helpful adjunct to psychotherapy and the decision to utilize any technique is entirely yours. The services offered can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, mental health services have also been shown to have benefits for people. Treatment may often lead to changes in relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Confidentiality

The code of ethics of the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board and other counseling boards insure that the conversations you will be having with your counselor will be held in strict confidence. There are, however certain exceptions to this important rule. The Notice of Privacy Practices explains this information in detail.

1. The child abuse reporting laws of Ohio require your counselor to report to Children's Services any suspected physical, sexual, or emotional abuse, neglect or abandonment of any child that is currently under the age of 18 years.
2. Your counselor is mandated by law to warn and protect any intended victim if there is reason to suspect bodily harm toward yourself or someone else. Your counselor reserves the right to inform possible affected parties and/or make appropriate referrals, if necessary, including contacting the police.
3. Ohio law requires professionals to report elder abuse, neglect, exploitation, or the suspicion of abuse to the Department of Human Services.
4. If you are involved in a court proceeding and a request is made for information concerning your treatment, your counselor cannot provide such information without your (or your legal representative's) written authorization, or a court order. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
5. If a government agency is requesting the information, your counselor may be required to provide it.
6. If you file a complaint or lawsuit against your counselor, he/she may disclose relevant information about you in order to defend him/herself.

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Danielle Weatherholtz, LPCC Michelle Jordan Frias, LISW

7. If you file a worker's compensation claim, your therapist may, upon appropriate request, have to provide a copy of your records or a report of your treatment.

Supervision

If your therapist is working under Supervision, as defined by Ohio Counselor, Social Worker, and Marriage and Therapist Board, by signing below you agree that your therapist will discuss your case with his/her Supervisor and that the Supervisor, as listed at the top of this agreement will have full access to your Protected Health Information as well as the clinical information about your case.

Consulting with Other Therapists and My Attorney

By signing below you agree that your therapist will consult with other therapists and possibly other health care providers about your care. In addition, from time to time, your therapist may feel the need to discuss legal issues involving your case with her consulting attorney. By signing below you consent to these consultations, which will be limited to the amount of information necessary for your therapist to properly address issues that may arise in your therapy.

Electronic Communication

Electronic messages (email, text messages, etc.) are vulnerable to breaches of privacy, despite standard safeguards, which are outside our control. Therefore, we are unable to exchange clinical information with you by electronic communication. We can communicate regarding scheduling or billing issues if the message is initiated by you. By signing this consent, you agree to these conditions and understand, and agree to the fact, that if you initiate an email or text message to us, your identification, information that you are communicating with a therapist, and/or other Protected Health Information could inadvertently be disclosed to an outside party.

Health Information

The Notice of Privacy Practices* (NPP) explains in more detail your rights and how we can use and share your information.

*If you would like a copy of the "Notice of Privacy Practices" which explains this information in detail, one can be provided to you at your initial appointment. This document is also available online at https://santelandkerr.com

Prohibition of audio, video or photographic recording

While in counseling/psychotherapy sessions and/or in the waiting room of Santel & Kerr LLC, there is to be no audio, video or photographic content recorded. By signing below you agree to not use any type of documenting device or recording device while attending counseling, and that doing so could lead to termination of your treatment.
If, due to unusual circumstances, you would like to record or videotape your individual psychotherapy/counseling session, and if your therapist deems an exception to this prohibition is reasonable and necessary, the exception will be granted to you in writing.

Insurance and Fees

Please review this agreement before signing. By signing this form you agree to abide by the fee agreement. You also understand that you are financially responsible for the amount of charges not covered by your insurance.

You understand that you are responsible for obtaining necessary insurance authorization/referrals and for confirming coverage and agree to notify your therapist of any changes in insurance coverage.

By signing this form you acknowledge that although insurance will be billed directly as a convenience to you, that you are responsible for the balance of your account for services rendered, regardless of any payments or promise of payment by your insurance company or other third party. Prompt payment is expected from you of any insurance payments made directly to you for counseling services, or of any co-payments, deductible payment, etc. due from you.

Payment is expected on the day of service. You understand that if you choose to not submit an insurance claim, you will be expected to pay full cash fee. The full cash fee for a counseling session is $120.00 per 1 hour (50 minutes) session.

By signing below you understand that in the event that if you or your insurance company do not pay for services that Santel & Kerr LLC may send your information to a collection agency to collect any balances due, including an upcharge of 25% of your fees for administrative costs. If this occurs, your therapist will only release enough information about you to collect the debt. It is asked that every client authorize payment of medical benefits directly to Santel & Kerr LLC and/or your therapist.

By signing this form below I understand that if your therapist is required to bill the Bureau of Workers Compensation and/or any of the associated managed care organizations, the rate of reimbursement increases to $150.00 per therapy hour due to the increased amount of paperwork, documentation, collaboration, phone calls, etc. required by these organizations.

By signing this form below, both you and your attorney understand that if you are part of court proceedings, that your therapist must be paid for counseling/psychotherapy services ongoing throughout treatment and not at the completion of the case.

By signing below you consent to the disclosure of necessary information to your insurance company, which is required for billing (diagnosis, treatment plans, dates of service, and, if required, treatment progress). You also give consent to bill your insurance company for services rendered and allow a photocopy of your signature to be used.

Individuals have the right to restrict certain disclosures of Protected Health Information to a health plan where the individual pays out of pocket in full for the healthcare item or service. You understand that you have this choice in your treatment.
I choose to self-pay out of pocket: Y____ N_____

Primary Insurance Company: ____
Co-Pay Amount: ____
Name of Insured on Insurance Card:____
Date of Birth of Insured on Insurance Card:____
Member ID:____
Group Number: ____
Insurance Contact Phone number for Providers:
____

* Please call your insurance company to verify coverage and copay amount, and **if there is a deductible to be met first.**

Secondary Insurance Company: ____
Co-Pay Amount: ____
Name of Insured on Insurance Card:____
Date of Birth of Insured on Insurance Card:_______________________________________
Member ID:____
Group Number: ____
Insurance Contact Phone number for Providers:____
*Please call your insurance company to verify coverage and copay amount, and **if there is a deductible to be met first**.

CANCELATION POLICY:

By signing this document and initialing below, you understand that **you will be charged a minimum amount of $60.00 for late cancelations (appointments canceled without 24 hour notice), and a full session fee for appointments canceled within 6 hours of your appointment time and/or for no-show appointments**. Clients who repeatedly do not give a 24-hour notice for cancellations or who do not keep scheduled appointments may be terminated. You understand that insurance does not cover "missed appointment" fees or late cancel fees. Initialing below, you are stating understanding regarding the collections process noted in above section.

You understand that you are responsible for filing complaints or suits against your insurance company if they deny or delay payment on an eligible visit, or decline payment for any reason.

Initial: _______________

You have had the opportunity to discuss this consent with your therapist and do hereby give full voluntary consent/ authorization for the treatment for yourself and or your child/family under the conditions set forth.

Legal Proceedings

In the event that your therapist becomes involved in legal proceedings as a result of therapy, such as but not limited to responding to a court order or attending a deposition or a hearing, you agree to pay for fees in connection with such a proceeding. You also agree that your therapist may consult with his/her attorney on how best to proceed and you agree to pay those legal costs. Time for depositions and court may involve preparation, travel time, and waiting to testify. In such situations your therapist may request a retainer which will be charged at the normal rate charge at that time for therapy. If any money in the retainer is not used your therapist will refund the balance. In the event that your therapist does not schedule patients in anticipation of a court proceeding and notice of a cancellation of the court proceeding within one week of its scheduled date is not received, you agree to pay for time your therapist lost with patients that would have otherwise been scheduled.

By signing below you understand that your therapist is not a forensic psychologist and is limited by the Board's guidelines regarding conflict of interest and scope of practice as to what testimony, if any, may be given.

Professional Records

The laws and standards of our profession require that your therapist keep Protected Health Information about you in your Clinical Record. If records are requested copied for another provider, legal proceedings, etc., in most circumstances, your therapist is allowed to charge you or your personal representative a copying fee of $2.74 per page for the first ten pages, $.57 per page for pages 11 through 50, and $.23 per page for pages 51 and higher, plus the cost of any related postage.

Therapist Incapacity or Death

By signing this consent you acknowledge that in the event of your therapist becoming incapacitated or death, it will become necessary for another therapist to take possession of your file and records. You give consent to allow another mental health professional at Santel & Kerr LLC to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice. You agree to select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional of your selection.

Signature of Agreement:

If you have any questions or concerns about the information presented to you in this form, you can speak with your counselor at any time. Signing below indicates that you have read and understand that there are limits on confidentiality, there is a fee and payment procedure and that you hereby give your consent and permission for all listed above.

Your signature certifies that you have either received a copy of the "Notice of Privacy Practices" or waived that right. You understand that you can obtain a copy at any time from your counselor or online via the website.

By signing below, you are agreeing to all information outlined above for yourself and/or your child. You consent to receive the services outlined above or you consent for your child, who is under the age of eighteen (18) to receive these services.

Client Name (Please print): ____

____ ____
Client's Signature Date

____ ____
Parent/Legal Guardian Signature for a minor under 18 years of age Date

Minor Seeking Treatment:

As a minor 14 years of age or older, I understand I am entitled to receive counseling services for not more than six sessions or thirty- (30) days, whichever comes first, without the consent of my parent/guardian and without that parent/guardian being informed. If services extend beyond that point, I will work with my therapist to involve my parent / guardian in my treatment.

Minor Signature ____ *Date:* ________________________