Informed Consent for Psychotherapy

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Informed Consent for Psychotherapy General Information

The therapeutic relationship is unique in that it is a 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.

Information About Me

Prior to beginning treatment, I will discuss my professional background and provide you with information regarding my experience, education, special interests, and professional orientation.

You may also learn more at my website: https://elizabeth-bevan.clientsecure.me

I am a Licensed Marriage and Family Therapist, my license number is LMFT 129744.

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 your repeating patterns, as well as to help you clarify what it is that you want for yourself.

Therefore, it is my intention to provide services that will assist you in reaching your goals. We are partners in the therapeutic process. As partners, we will work together to develop a plan for your treatment, determine progress of your treatment and decide when you have completed treatment.

The amount and length of treatment varies from patient to patient. I am unable to predict how long you will be in therapy or guarantee a specific outcome or result of our work together.

Therapy sessions are approximately 55 minutes each session. Typically, sessions are scheduled once per week, at the same day and time each week. Consistent attendance contributes greatly to a successful outcome.

Telehealth

Currently, I only offer services via telehealth. During session I ask that you:

- Find a space that is confidential and is free of distraction.
- Do not drive or operate another vehicle.
- Can use video for your telehealth session.

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 themselves 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 to provide the best treatment for you. Information about you may be shared in this context without using your name or any other identifying information. 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.

Fees and Insurance

The fee for Intake Assessment service is $ 160 per intake Assessment.
The fee for Individual therapy service is $ 135 per individual session.
The fee for Collateral service is $135 per collateral session.

The fee for phone consults or check-ins is $30 per 15 minutes, after the first 15 minutes (the first fifteen minutes are free).
The fee for writing letters is $50 for this 1st page and $25 for each additional page. (Letters will only be written for clients who have attended 8 or more therapy sessions.)

Fees are payable at the time that services are rendered. I accept payment in the form of debit or credit card. I utilize Path, Headway and Simple Practice as my billing and payment reimbursement platforms. It is my goal to maximize your session time. Therefore, if you are paying for a session via a debit card or credit card please let me know ahead of time so I can collect and/or provide the necessary information.

You are ultimately responsible for payment for services received, even if you are relying on, or expecting your insurance company or another third-party payor to cover the costs of your treatment. I will notify you in the event of any changes to fees or when other charges are to be applied. If you are experiencing financial difficulty, please let me know so we can discuss your options for care.

If you will be using health insurance to pay for your services, please discuss this with me to determine if I am an in-network provider for your plan. If I am a contracted provider with your insurance company, I will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or co-insurance payments depends on the requirements of your specific insurance plan. Please be aware that insurance plans generally limit coverage to diagnosable mental conditions. You are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee that your insurance will provide payment for the services provided to you.

My Medicare Provider Status

Please be aware that**:**

I am an Opted-Out provider. This means I am not contracted with Medicare. Medicare will not reimburse you for the cost of my services. If you are a Medicare beneficiary, we will need to enter into a private contract for therapy services in order for me to treat you.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur once per week on the same day at the same time, if possible. I may suggest a different amount or frequency of therapy depending on the nature and severity of your concerns. Your consistent attendance can greatly contribute to a successful therapy outcome. To cancel or reschedule an appointment, please notify me at least 24hours in advance of your appointment. **If you do not provide me with at least 24 hours' notice of a cancellation, I will charge you $99 for the missed session.** If you are using insurance, please be aware that your insurance company will not pay for missed or cancelled

sessions. Accordingly, you will be responsible for covering the cost of missed sessions and sessions cancelled within 24 hours of the scheduled session.

My Communication With You

From time to time, I may need to communicate with you outside of our sessions together to discuss scheduling, payment, or other issues related to your treatment. To respect your privacy, it is important for me to understand your communication preferences. Please indicate your openness to receive communication from me via the following methods:

Phone

My Home Phone Number is _____

☐ I authorize my therapist to call me at this number

☐ I authorize my therapist to leave messages for me at this number

My Cell Phone Number is _____

☐ I authorize my therapist to call me at this number

☐ I authorize my therapist to leave messages for me at this number

Additional Information About Unencrypted Text Messaging: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted text, such as technological failures or unintended access by third parties.

☐ I understand the information above and authorize my therapist to communicate with me via unencrypted text using the cell phone number I provided.

Email

My Email Address is _____

Additional Information About Unencrypted Email: I value your privacy and take appropriate steps to preserve the confidentiality of information shared between us. However, it is important to be aware that certain risks may still be present when communicating via unencrypted email, such as technological failures or unintended access by third parties.

☐ I understand the information above and authorize my therapist to communicate with me via unencrypted email at the email address I provided.

Mail

My Home Address is _____

☐ I authorize my therapist to send necessary, treatment-related information to me at this address.

Additional Communication Information and Preferences

Please feel free to inform me if there are additional communication preferences you would like for me to be aware of, or if you do not wish to be contacted at a particular time, place, or by a particular means.

I will do my best to honor your communication preferences, but please be aware that in certain instances, such as emergency circumstances, I may need to reach you through other methods.

Emergency Contacts

It is critical for me to know who I can contact in the event that you are experiencing a medical or psychiatric crisis or other emergency circumstance. Please identify these individuals in the space provided below:

Emergency Contact 1

Name _____

Relationship to Patient _____

Home Phone Number _____

Cell Phone Number _____

Emergency Contact 2

Name _____

Relationship to Patient _____

Home Phone Number _____

Cell Phone Number _____

Emergency Contact 3

Name _____

Relationship to Patient _____

Home Phone Number _____

Cell Phone Number _____

Your Communication With Me

Nonurgent Communications

My preferred methods of communication are as follows:

Phone: 707-245-3494. (I respond to both text messages and phone calls).

Email: Elizabeth BevanLMFT@pm.me

If you would like to contact me in-between sessions to discuss a nonurgent issue, such as scheduling or payment, please do so during my normal business hours of Monday through Thursday 10am to 5pm.

Please understand that I may be in session with other patients or addressing other matters when you attempt to reach me. If you send or leave me a message, I will respond as soon as I am available, but please be aware that I may respond to your communication up to 24 business hours after receiving your message. As I do not work Friday-Saturday, I will not respond during these days.

Urgent / Emergency Communications

If you are ever experiencing a medical or psychiatric emergency or if you are facing an emergency involving a threat to your safety or the safety of someone else, please call 911 to request emergency assistance. In the event of a mental health crisis, you may also call the 988 Suicide & Crisis Lifeline by dialing "988."

Therapy Across State Lines

Unfortunately, I may not be able to treat you while you are physically outside of the state of California. My ability to do so depends on various factors, such as the laws of the jurisdiction you will be traveling to. If you know you will be traveling outside of the state, please provide me with as much advance notice as possible so I may have enough time to determine whether I will be able to provide treatment to you during that time.

If you are paying for therapy via health insurance or another third-party payer, advance notice of your travel plans will also allow us to discuss whether your plan covers therapy across state lines and/or alternative payment options, if necessary and appropriate. Please be aware that not all plans cover therapy across state lines.

If I am unable to treat you while you are outside of California, we can discuss alternative care options and strategies as well as what you should do in the event of an emergency.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on your clinical needs, the specifics of your treatment plan, and the progress you make towards achieving your treatment goals. While I hope you will find our time together beneficial and meaningful, I cannot guarantee the specific outcome(s) or result(s) your treatment will yield.

You may discontinue therapy at any time. If one of us determines you are not benefiting from treatment, we can discuss treatment alternatives. These alternatives may include, among other possibilities, changes to your treatment plan, referrals to other therapists, and/or termination of treatment.

Questions About My Policies

Please let me know if you have any questions about my policies or if you would like to discuss them further.

Informed Consent

Your signature below indicates that you have read this agreement for services and disclosures carefully, understand its contents, and consent to receive treatment from me.

_____

Name

_____

Patient's Name (If You Are Not the Patient)

_____

Relationship to Patient (If Applicable)

_____

Signature

_____

Date