**Therapy Consent, Policies & Agreement**

**PART I: THERAPEUTIC/COUNSELING PROCESS**

**BENEFITS/OUTCOMES:** The therapeutic process seeks to meet goals established by all persons involved, usually revolving around specific identified counseling needs. Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one’s ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of counseling.

**EXPECTATIONS:** In order for clients to reach their counseling goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the counseling process, we identify goals, review progress, and modify the treatment plan as needed.

**RISKS**: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of counseling may not be reached.

**STRUCTURE OF COUNSELING**:

* **Intake Phase** – During the first session, the therapeutic/counseling process, structure, and policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
* **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic/counseling needs, I will provide referrals for more appropriate treatment.
* **Goal Development/Treatment Planning** – After gathering background information, we will collaborative identify your counseling goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
* **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in counseling sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
* **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

**LENGTH OF COUNSELING**: **Counseling sessions are typically weekly for 50-60 minutes per session depending upon the nature of the presenting challenges and type of session, unless the session is a family session with the minor client present or is a marital/couples counseling session that are typically 60-75 minutes per session.**  It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session-to-session what the next steps are and how often counseling sessions will occur.

**APPOINTMENTS AND CANCELLATIONS**: You are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment within 24 hours of the scheduled appointment time. Otherwise, you will be required to pay a $50 no show/late cancellation fee. If you cancel or rescheduled more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time.***

***Please Note: It is important to maintain consistent counseling appointments in order for counseling to be effective and beneficial. Should there be interruptions to counseling such as multiple consecutively missed appointments or non-activity/non-participation of counseling services for 90 days, then the counselor reserves the right to discharge you from counseling services.* The counselor reserves the right to terminate the counseling relationship if 3 consecutive sessions are missed without proper notification and/or payment is not rendered for counseling services.**

Counseling sessions may be briefly interrupted due to the counselor periodically taking time off for vacation, seminars/trainings, and/or become ill. Attempts will be made by the counselor to give adequate notice of these events.

**FEES**: **The full flat fee per counseling session is $100 (including intake session, individual counseling session for child/adolescent/adult, parent session without the minor present (if applicable), and family session with the minor client present). The full flat fee per marital/couples counseling session is $150. The payment is due at the time of service. Acceptable forms of payment are: exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus $25 for any returned check), or most major credit cards.** In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the “Appointments and Cancellations” policy above.

**The counselor charges her hourly rate in quarter hours (e.g., $25 for 15 min., $50 for 30 min., $75 for 45 min., and $100 for 60 min.) for phone calls over 10 minutes in length. It is strongly encouraged and recommended to schedule an appointment to discuss your current concerns or issues to protect your confidentiality.**

**A $50 fee is required for requested letters to professionals (e.g., school related) and/or collaboration and coordination with necessary professionals (with your written permission) for continuity of care purposes.**

***All costs for services outside of session will be billed, and is expected to be paid before the next scheduled session.***

**TRIAL, COURT ORDERED APPEARANCES, LITIGATION**: Rarely, but on occasion, a court will order a counselor to testify, be deposed, or appear in court for a matter relating to your treatment or case. **In order to protect your or your child’s confidentiality, I strongly suggest not being involved in the court as I have found this damages the therapeutic relationship. If I get called into court by you or your attorney, or your child’s attorney you will be responsible for paying a $2,500 fee prior to any court appearance, which includes the counselor’s travel time, counselor’s attorney, court time, preparing documents, etc.**

**COPIES OF MEDICAL RECORDS**: Should you request a copy of your or your child’s **medical records, the cost is $1.00 per page**. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. **Please allow at least 2 weeks to prepare medical records.**

**Per Virginia Code §20-124.6, the parent or legal guardian has the right to access the child’s medical records; however, receiving a copy of your child’s medical records can damage confidentiality and the therapeutic relationship. As a means to protect your child’s confidentiality per the HIPAA Privacy Rule (45 CFR 164.524), upon your request, the medical records can be summarized in lieu of releasing your child’s medical records. The fee associated with preparing the medical records summary is $100, and please allow 2 weeks to process your request.**

**COMPLAINTS:** If you have a complaint about my services, I hope that you will bring this up with me and make every attempt to work through the issue. However, if this does not work, you have the right to make a formal complaint to my licensing board: Virginia Department of Health Professions Board of Counseling, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233-1463, or by telephone at 1-800-533-1560. The Virginia Department of Health Professions Board of Counseling website can be located at https://www.dhp.virginia.gov/Boards/Counseling/.

**PHONE CONTACTS AND EMERGENCIES**: **Flexible office hours are available from 10:00 am to 6:00 pm, Monday through Friday. However, the office may be closed in observance of holidays. If you need to contact the counselor for any reason please call (757) 533-2266, leave a voicemail, and a return call will be made at least 24 hours or as soon as possible.**  *In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255 or text 988 for the Suicide and Crisis Lifeline or contact the Crisis Hotline at 627-5433 or the local Crisis Hotline (Chesapeake City Crisis Care Emergency Line) at 757-455-0368. If either you or someone else is in danger of being harmed, dial 9-1-1 or please contact your local emergency services crisis line for additional assistance or please go to the nearest hospital for immediate assistance.*

**PART II: CONFIDENTIALITY**

Anything said in counseling is confidential and may not be revealed to a third party without written authorization, ***except*** for the following **limitations**:

* **Child Abuse** - Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child-on-child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
* **Vulnerable Adult Abuse or Neglect** - If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
* **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client’s safety, which may include disclosure of confidential information.
* **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
* **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you by phone so you may take whatever steps you deem necessary to prevent the release of your confidential information. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
* **Court Ordered Therapy**: If counseling is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
* **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of the actual medical record except if the third party is needed for medical purposes. If counseling sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
* **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e., your signature on the “Therapy Consent & Agreement” that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur). If there is a financial balance on the account, a bill will be sent either to the home address on the intake form or via email unless otherwise noted.
* **Marital/Couples Counseling & “No Secret” Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a “secret” that is detrimental to the marital/couple’s counseling goal. If one partner requests that I keep a “secret” in confidence, I may choose to end the therapeutic relationship and give referrals for other counselors as our work and your goals then become counter-productive.
* **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this therapeutic relationship, it is imperative that there is no relationship outside of the counseling relationship (i.e., social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
* **Social Media**: No friend requests on my personal social media outlets (e.g., Facebook, LinkedIn, Pinterest, Instagram, Twitter, Google, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace counseling. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of the medical record.
* **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone contact.** 
  + **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the counselor–client relationship.**  Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client’s phone.
  + **Do not use e-mail for emergencies**. In the case of an emergency call 9-1-1, or your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to schedule an appointment.
  + **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

**PART III: REASONS I DO NOT ACCEPT INSURANCE**

* **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require “preauthorization” before you can receive services. This means you must call the company and justify why you are seeking counseling services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company’s list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.
* **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several counseling sessions at a time. When these sessions are finished, your counselor must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the counselor justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.
* **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require clinicians to give a mental health diagnosis (i.e., “major depression” or “obsessive-compulsive disorder,” etc.) for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (i.e., divorce court, family law, criminal, etc.).

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marital/couples counseling.

**Why Counselors Do Not Take Insurance:** These involve enhanced quality of care and other advantages:

1. You are in control of your care, including choosing your counselor, length of treatment, etc.
2. Increased privacy and confidentiality (except for limits of confidentiality).
3. Not having a mental health disorder diagnosis on your medical record.
4. Counseling issues that are non-psychiatric issues that are important to you that are not billable by insurance, such as learning how to cope with life changes, gaining more effective communication techniques for your relationships, increasing personal insight, and developing healthy new coping skills.

After reading my position on why I do not accept health insurance, you still may decide to use your health insurance or in-network care. If so, I will do my best to recommend an in-network counselor for you. However, I do provide the option for insurance reimbursement (i.e., “superbill”) upon your request, but superbills may potentially be denied for reimbursement since counseling services are out-of-network for insured individuals.

**EMERGENCY CONTACT:**

It is necessary that **Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor) at **Davis Counseling & Play Therapy Center, PLLC** has someone to contact on your or your child’s behalf in case of an emergency situation. In case of an emergency who should we contact?

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Please check here that you agree and sign below. Thank you.

☐ I agree to allow **Davis Counseling & Play Therapy Center, PLLC** to contact my emergency contact on my behalf in the case of an emergency.

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**PART III: CONSENT**

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor). My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor) to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part II above) from Davis Counseling & Play Therapy Center, PLLC that is necessary to process bills for services **to my insurance company (if utilizing the superbill option)**. I acknowledge that I am financially responsible for payment whether or not the counseling service(s) is covered by my insurance or not, and I do not hold **Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor) at **Davis Counseling & Play Therapy Center, PLLC** liable should insurance claims for reimbursement be denied.

3. **Informed Consent with Minors (under the age of 18):** **I hereby certify that I have the legal right to seek counseling treatment for the minor in my custody and give permission to Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor) **to provide treatment to my minor child.** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation (i.e., most recent or current custody/visitation agreement, divorce decree, court order, etc.) to **Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor) prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session. In situations where parents have joint-legal custody, both parents need to consent both orally and in writing that they agree and consent for counseling treatment to occur for their minor child with **Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor) at **Davis Counseling & Play Therapy Center, PLLC.**

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| **Printed Name** | **Signature** | **Date** |
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*Your signature signifies that you have received a copy of the* “Therapy Agreement, Policies and Consent*” for your records.*

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| **Printed Name of Minor Child** | **DOB** | **Date** |
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Witness – Date

**Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor)

**CLIENT COPY**

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor). My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor) to provide counseling services that are considered necessary and advisable.

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| **Printed Name** | **Signature** | **Date** |
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*Your signature signifies that you have received a copy of the* “Therapy Agreement, Policies and Consent*” for your records.*

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Witness – Date

**Suzanne Davis, LPC (Virginia), RPT-S™** **(Registered Play Therapist-Supervisor™)** (counselor)