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Treatment Philosophy – Brief Therapy Explanation

The therapist believes in providing goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal in a time-efficient manner. I will take an active role in setting and achieving my treatment goals. My commitment to this treatment approach is necessary for me to experience a successful outcome. If I ever have any questions about the nature of the treatment or anything else about my care, I will not hesitate to ask. **Initial here:_____**

Confidentiality Statement

I understand that all information between provider and patient is held strictly confidential unless:

1. The patient authorizes a release of information with his/her signature.
2. Injuries resulting from spousal abuse or other assaultive conduct.
3. If your mental condition becomes an issue in a lawsuit.
4. The patient presents a danger to others.
5. Child or Elder abuse/neglect is suspected.
6. The patient presents a physical danger to self.

I understand in the latter three (3) cases, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless I give written permission to release all or part of the information to a specified person, persons or agency. If I participate in group counseling, I agree not to discuss any details of the group discussion outside of counseling sessions.

Initial here:_____

Release of Information

I authorize release of information in the course of consultation or professional communication with the professional referral source and other health care providers and institutions for purposes of diagnosis and treatment. I further authorize the release of information for claims, certification/case, management, quality improvement and other purposes related to the benefits on my health plan. **Initial here:_____**

Emergency Access

The therapist is available after hours to handle emergency (life-threatening) situations. By calling the office number the therapist will return the call as quickly as possible. **Initial here**_____

Financial Terms: Insurance Coverage/Co-payments

I am responsible for obtaining any prior authorization for treatment from my insurance carrier. My insurance will be billed; however, I am responsible for co-payment amounts and deductibles as set by my benefit plan. Missed sessions and sessions not covered by my insurance are also my responsibility. Co-payment amounts are set by my benefit plan. These payments are due and payable at each appointment. The co-pay amount set by my plan for each visit is as follows:

1-5 visits: \$_____ 6-10 visits: \$_____ 11-20 visits: \$_____ 21-25 visits: \$_____
26-50 visits: \$_____

At any time during my treatment, I become ineligible for coverage by my insurance, I will be responsible for 100% of my bill. **Initial here:**_____

Consent for Treatment

I authorize and request my therapist carry out psychological examinations, treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while my course of therapy is designed to be helpful, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, anger, etc. I am aware that this is a normal response in talking about unresolved life experiences and will be worked on between me and my therapist.

Initial here:_____