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Informed Consent and Disclosure

My responsibilities to you as your therapist
I. Confidentiality

You have the right to absolute confidentiality in therapy with the exception if the specific circumstances described below. I cannot and will not tell anyone else what you have told me, or even that you are in counseling with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever your chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPPA). The law ensures the confidentiality of all electronic transmissions of information about you. Whenever I transmit information about you electronically (i.e., sending bills), it will be done with safeguards to ensure confidentiality.

If you elect to email or text me at some point in our work, please be aware that email and texts are not completely confidential. All emails and texts are retained in the logs of your or my phone/internet service provider. While under normal circumstances, no one looks at these logs, they are in theory, available to be read by the system administrator(s). Any email I receive from you, and any responses that I send to you will be printed out and kept in your file.

The following are the legal exceptions to confidentiality:

- If I have good reason to believe that you will harm another person I must attempt inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.
- If I have good reason to believe that you are abusing or neglecting a child or a vulnerable adult, or if you are a child or vulnerable adult and you are being

abused or neglected, or you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

- If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or a county crisis team, and tell your parents (if you are a minor). I would explore all other options before I took this step but if you were unwilling to take steps to guarantee your safety, I would need to break confidentiality.
- If you tell me of another mental health provider or health provide has engaged in either a) sexual contact with you or another patient or b) is impaired from practice in some manner by cognitive, behavioral, or health problems, then the law requires me to report this to their licensing board. I would inform you before taking this step.

II Record keeping

I keep limited records noting the intervention used, topic discussed in therapy and clinical impressions. Under the Health Care Information Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

III Diagnosis

If a third party such as a insurance company is paying fro part of your bill, I am often required to have a diagnosis in order for services to be paid. Diagnoses are technical terms that describe the nature of your difficulties. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book called the DSM-5. You may borrow my copy of this book and learn more about what it says about your diagnosis at any time.

IV Other rights

I am always willing to discuss what I am doing and to look at alternatives that might work better. You can I to be referred to someone else if you do not feel that I am the right fit for you/your child. You/your child are/is free to leave therapy at any time.

Your responsibilities as a client

You are responsible for coning to sessions on time and at the time that we have scheduled. Sessions last for 50 minutes. If you are late for a session we will send on time and not run over into the next client's session. If you miss a session without cancelling, or you cancel within less that 24 hour's notice, you must pay for the session at our next regularly scheduled session.

Rates

My current rate is $150 for a 50-minute session. Reduced rates are potentially available depending on circumstances. Payment is due at each session by cash, check or credit card.

Insurance

Services for therapy may be covered fully or partially by your health insurance. If you have a PPO, you may be eligible to be reimbursed at an out-of network rate. It is your responsibility to find out what coverage you have and f it has any limits/limitations. I do not submit claims directly to your insurance company for any reimbursement you are eligible for. Some questions that you may wish to ask your insurance company ahead of time when determining coverage are:

- Does my policy provide mental health insurance benefits?
- Is there a deductible? Have I met it yet?
- How many counseling sessions doe my plan cover per year?
- What counts as an out-of network provider?
- How much reimbursement would I receive when using an out-of network provider?
- Does my primary care physician have to give approval/refer me?

Rescheduling/cancellation policy

Therapy requires regular attendance for it to be effective. If you call ahead of time to reschedule an appointment I may be able to get you in sometime the same week. If you do not attend a scheduled appointment without calling me at least 24 hours before the appointment time, you will be charged the same as what you would pay for a normal session.

Client consent to counseling

I have read this statement, had sufficient time to be sure that I considered it carefully, asked any questions that I needed and I fully understand it. I understand the limits of confidentiality by law. I consent to the use of a diagnosis in billing, and to the release of information and other information needed to complete the billing process. I agree to pay $150 per session. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to undertake therapy with Dr. Alison Englar-Carlson. I know that I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Dr. Alison Englar-Carlson.

Singed: ____

Client/Client's parent/guardian

Print name: ____

Witness: ____

Print name: ____