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Informed Consent for Treatment

This document contains important information about my professional services and business policies, your rights as a therapy client, and disclosures of information. Please read it carefully and jot down any questions that you might have so that we can discuss them at this or our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Individuals or families usually seek counseling/therapy to work through difficult situations or particular problems. Counseling/therapy is intended to assist clients in achieving a higher level of functioning. The purpose and overall goal of therapy is to assist in addressing and reducing the influence of the presenting problem.

Counseling/therapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client, on the particular issues that the client brings and on the therapeutic techniques used. There are many different methods that I may use to assess and deal with the problems that you hope to address. They may include: EMDR (Eye Movement Desensitization and Reprocessing), Cognitive Behavioral approaches, EFT (Emotionally Focused Therapy), Redecision Therapy, Mindfulness therapy, Dreamwork, Bibliotherapy, and other techniques and procedures as needed. Counseling/therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will need to work on things we talk about both during our sessions and at home.

RISKS

Counseling/therapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, ***but there are no guarantees*** that you will experience these improvements.

MEETINGS

My normal practice is to conduct a preliminary evaluation that may last one or two sessions. I will report to you whether I believe I can help you with your situation, or I will suggest another qualified professional who may have specific skills that would better benefit you. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinion about whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy; so, you should be very careful about the therapist you select. I encourage you to ask questions. If you have questions regarding my procedures, we should discuss them whenever they arise. If therapy is begun, I will usually schedule one 55-minute ('therapy hour') session per week at a time we both agree on. **Once an appointment hour is scheduled, you will be expected to pay for it in full unless you provide 24 hours advance notice of cancellation**.

PROFESSIONAL FEES & SERVICES

My hourly fee for therapy sessions is ***$175.00/hr*** for individuals and ***$200/hr*** for couples. In addition to weekly appointments, I charge this amount for other professional services you may need, though I break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time performing any other service you may request of me. **The scope of my practice does not include participation in any way with cases that require my involvement in legal proceedings**.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held.

If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. I will avoid using a collection agency or small claims court unless absolutely necessary. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information that I release regarding a patient's treatment is her/his name, the nature of services provided, and the amount due. I strongly encourage you to talk with me directly if you are having financial difficulties so that we can work out a suitable plan.

CONTACTING ME: I am not immediately available by phone at most times. While I am in the office, I will not answer the phone while I am with a client. My phone is answered by voicemail which I check frequently. On my business days, I make every effort to return your call that day. I am not available on a 24-hour-a-day basis. **If you have an emergency, and you feel you cannot wait for me to return your call, you should call your family physician or psychiatrist, a suicide hotline (800) 273-8255, or the emergency room and ask for the psychiatrist on call.** If I will be unavailable for an extended period of time, I will notify you in advance of my absence and give you the name and telephone number of a trusted colleague. I can be reached by email or text for **scheduling purposes only**. Please do not leave detailed information via electronic means.

MINORS

If you are under 18 years old, please be aware that the law may provide your parents/guardian the right to examine your treatment records. It is my policy to request an agreement from parents/guardians, in the form of this statement that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel that there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with general summaries of your treatment. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections that you may have with what I am prepared to discuss.

INCLEMENT WEATHER POLICY

My office follows inclement weather decisions made by the Wake County Public School System. If Wake County cancels school or has a delay, I will adhere to that decision. I will also contact you to reschedule.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a counselor is protected by law, and I can release information about your work to others only with your written permission. But, there are a few exceptions:

- In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody those in which your emotional condition is an important element, a judge may require testimony, if he/she determines that the issues demand it.
- There are some situations in which I am legally obligated to take actions to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child or vulnerable adult (i.e. an elderly or disabled person) is being abused, I must file a report with the appropriate state agency.
- If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If a patient threatens to harm herself/himself, I may be obligated to seek hospitalization for him/her or to contact family members or others who may help provide protection.

PROFESSIONAL CONSULTATION

To bring you the best care, I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. I will not tell you about these consultations unless I feel that it is important to our work together.

Consent for Treatment Signature Page

Please INITIAL each of the following statements and sign below:

_____I have received a copy of the Notice of Privacy Practices and the Client's Rights

_____I understand that Alison Sanderson will not disclose to anyone that my child, my family, or I are involved in counseling services with her unless I give my permission. I also understand that Alison Sanderson will not disclose any information about me, my child or my family to anyone else without my permission. I understand that she engages is case consultation and will not divulge identifying information.

_____I understand that there are limits to confidentiality. These include, but are not limited to: if I threaten to harm either myself or someone else, if I am suspected of abusing or neglecting a child, if I am involved in litigation and inform the court of the services I receive from Alison Sanderson, or if I am using insurance to reimburse for fees.

_____I understand that Alison Sanderson is not trained in matters that involve the legal system. I also understand that Alison Sanderson does not conduct forensic interviews regarding child custody or child welfare and that she does not provide affidavits. I understand fully that Alison Sanderson does not willingly participate in any court related matters. This includes but is not limited to child custody and personal injury cases and divorce. I agree that if Alison Sanderson is deposed, subpoenaed, or if she is otherwise compelled to give testimony regarding myself or my child that I will be pay her legal consultation fee of $350 per hour.

_____I have read and I accept Alison Sanderson 24 hour cancellation policy. I agree to pay the regular fee for appointments missed without 24 hour notice. I agree to provide credit card information below.

_____I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

_____I understand that in case of an emergency, I should call 911 or go to an emergency room.

Consent to Treat

I acknowledge that I have received and read the Informed Consent to Treat Document. I further acknowledge that I consent to and seek treatment from Sanderson Counseling, Inc contracted by Bull City Psychotherapy. My signature below confirms that I understand and accept all the information contained in the the Informed Consent to Treat.

_____ _____
Client Signature Date

_____ _____
Client Signature (if marital counseling) Date

_____ _____
Parent Signature (if client is minor) Date

Credit Card _____ Expires ___/___ Code _____ Zip Code_____