



Consent for Treatment

Welcome to Waterford Counseling and Psychological Services group practice. We are a group of clinicians dedicated to serving kids, adolescents, adults, couples and families. We appreciate the opportunity to serve you and/or your family. We invite you to carefully read the following information as it will outline the mutual responsibilities of the treatment agreement between you and your therapist, and also the mutual expectations between you and the group practice of Waterford Counseling and Psychological Services.

Confidentiality

All information shared within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. Medical records are kept in a confidential place for 7 years. When a written release is signed by the patient requesting records to be released, it is Waterford Counseling and Psychological Services Policy to release a treatment summary.

Limits of Confidentiality

There are exceptions to this rule of confidentiality mandated by state and federal laws. Written consent from the client is not required in the following circumstances: if there is a threat of imminent harm to yourself or others, if there is reasonable suspicion of child, dependent, or elder abuse or neglect, if you need immediate medical attention while in session or in the office, if records are required pursuant to legal proceedings initiated by or against you through a court order, if disclosure of confidential information is required by your health insurance carrier in order to process claims (only the minimum necessary information will be communicated to the carrier), or if your therapist feels the need to consult with other professional therapists as a part of the standard of good practice to ensure the best possible care for his or her client. During these consultations your personal identifiable information will not be revealed.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on your therapist at Waterford Counseling and Psychological Services to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. Should there be a court order that compels Waterford Counseling and Psychological Services to release these records, or that the therapist appear in court for any reason, then additional fees will be charged (**See Appointments and Fees Schedule**)

Payment and Insurance Reimbursement

Clients are required to pay all fees in full at the time services are rendered, unless alternative arrangements have been made with your therapist. If you have insurance coverage, you agree to assign the benefits of your insurance coverage to Waterford Counseling and Psychological Services, and to pay all deductibles and co-pays. We will submit claims to your insurance company on your behalf. Please understand that insurance policies are quite varied, and it is your responsibility to familiarize yourself with your insurance benefits, including obtaining any pre-authorizations required and verifying coverage. Our office will assist you with this process. It is important to realize, however, that regardless of your insurance coverage, it is ultimately the client's responsibility for payment of services.

Appointments and Fees

The client's initial appointment will be made through our Intake Coordinator. Subsequent appointments will be made by the client with their assigned therapist. The length of therapy sessions may be 25 minutes, 45 minutes, or 60 minutes. Fees for therapy sessions will be in accordance with the negotiated rate that we have with your specific insurance provider. Your therapist will discuss fees with you at the initial therapy session. Services not covered by Insurance may be charged to the client at the following usual and customary rates: \$180 for the initial session, \$160 for a 60 minute session, \$130 for a 45 minute session, and \$75 for a 25 minutes session. Clients may pay with cash, check, debit card, or credit card. Other fees that may be charged are as follows:

- Written Correspondence, letter and report writing: \$160 per hour
- Professional Consultation Services (Attorney meeting, etc): \$300 per hour

-Attendance at school/off site meetings: \$150 per hour

-Attendance in Court:

1. Preparation time (includes submission of records): \$300 per hour
2. Phone calls: \$300 per hour
3. Depositions: \$300 per hour
4. Time required in giving testimony: \$300 per hour
5. Mileage: \$.55 per mile
6. Time away from office due to depositions or testimony: \$300 per hour
7. All attorney fees and costs incurred by therapist as a result of legal action
8. Filing a document with the court: \$300 per hour
9. The minimum charge for a court appearance: \$2,000

Late Cancellations or No Show Appointments

Unless appointments are cancelled at least 24 hours in advance of the scheduled time, there will be an \$100 charge for missed or late appointments. We understand that emergencies do arise. Please discuss the nature of the emergency with your counselor to waive a late charge.

Social Media: Therapists do not accept friend requests from current or former clients on social networking sites, such as Facebook. We believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, we request that clients not communicate with any therapist via any interactive or social networking web sites.

Electronic Communication: It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on your therapist's computer may be encrypted, e-mails and e-fax are not. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Our computers are equipped with a firewall, a virus protection and a password, and all confidential information on our computer is backed up on a regular basis onto an encrypted hard-drive. Also, be aware that phone messages may be sent to therapists via unencrypted e-mails. Please notify your therapist if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, we will assume that you have made an informed decision, and we will view it as your agreement to take the risk that such communication may be intercepted, and your therapist will honor your desire to communicate on such matters. Please do not use texts, e-mail, voice mail, or faxes for emergencies.

Acknowledgment and Consent for Treatment

I have read the above Statement of Understanding and Consent for Treatment form and understand and agree to comply with the stated terms. I understand that Waterford Counseling and Psychological Services complies with all aspects of HIPPA regulations, the Mental Health and Developmental Disabilities Acts and to all other applicable federal laws and regulations. I affirm that I am consenting to be treated by my therapist. I understand that I will discuss the goals, objectives, methods and timeframe of my treatment with my counselor, understanding that these may be modified as therapy progresses. I am aware that I have the right to refuse treatment or to terminate counseling should I choose. I understand I can discuss the nature of the treatment to be employed, along with the risks and alternatives. I understand that I have the right to a copy of Waterford's Notices of Privacy Practices (HIPPA Form).

____(Initial) I would like a copy of Waterford Counseling's Privacy Practices Policy (HIPPA Form)

____(Initial) I decline a copy of Waterford Counseling's Privacy Practices Policy (HIPPA Form)

Name of Client (Printed)

Name of Legal Guardian (if client is under age 18)

Relationship to Client

Signature of Client (if over 18)

Signature of Legal Guardian (if client is under age 18)

Therapist's Signature _____

Date _____