Cheryl Outen, PhD, LPC
Office: (804) 214-6363 Fax: (804) 264-4852

Informed Consent & Agreement For Psychotherapy Services

I am pleased you have selected me as your therapist. This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask questions that you may have regarding its contents before signing it. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

THERAPEUTIC SERVICES OFFERED/THEORETICAL APPROACHES

Therapy is a process by which we work together to identify and work on any issues you bring to our sessions. I work with children, adolescents and adults dealing with anxiety, depression, trauma, grief, and other mood disorders. My therapeutic approach is eclectic typically blending the following: Person-Centered Therapy, Cognitive Therapy, Solution-Focused Therapy, and Dialectical Behavioral Therapy. I also may use some expressive arts techniques such as writing, art, and music during our sessions. Should you ever have reservations regarding therapy or any specific interventions, feel free to address your concerns with me.

THERAPEUTIC PROCESS

The purpose of meeting with a therapist is to get help with problems in your life that are bothering you, or that are keeping you from being successful in important areas of your life. Individuals may request therapy to discuss their problems, or because their family, guardian, doctor, or teacher express concerns about their behavior. The therapeutic process involves being able to explore and discuss these problems. I will ask questions, listen, and suggest a plan for improving these problems. Sometimes these issues will include things you don't want others to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their therapist. Privacy is an important and necessary part of good therapy.

POSSIBLE BENEFITS AND RISKS

Psychotherapy has both benefits and risks. Potential risks and unpleasant aspects may include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, and frustration. It is possible that you may experience some unpleasant emotions, including uncomfortable feelings or memories, questioning of relationships, and lifestyle adjustments. You might find yourself recalling some unpleasant aspects of your history. You may find yourself questioning and reevaluating some of your most cherished beliefs and values. It is important to consider that such experiences are a normal aspect of the counseling process, and I am available to talk over with you any of these issues as they may arise. Possible benefits of therapy involve reduction of feelings of distress, resolution of specific problems, and improvement in relationships with others. Of course, I cannot offer any guarantee of cure or any promise of improvement of any condition.

LIMITS OF CONFIDENTIALITY

Discussions between a Therapist and a client are confidential. No information will be released without the client's consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: situations where you pose a threat of serious harm to yourself or someone else; child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose.

If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist. By signing this Informed Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

CONFIDENTIALITY AND MINORS

Legally, clients (under the age of 18) have the right of confidentiality. To establish and preserve the essential relationship and setting for a child's therapy, I honor what the child or adolescent says or does in our sessions as confidential while providing parents/guardians periodic summaries of treatment goals, plans, recommendations, and progress.

RELEASE OF INFORMATION

I authorize the release of information as necessary for the purpose of the undersigned therapist obtaining consultation regarding my evaluation or treatment. I authorize the release of any and all information requested by my managed care company, insurance carrier, or third-party payor for the purpose of processing my insurance claim and obtaining payment for services. By authorizing the release of information to an insurance company or other third party, I understand that the information may become part of the third party's records and that the undersigned therapist can no longer control any subsequent release of that information. The undersigned therapist has informed me that should I ever authorize a general release of my medical records to or from an insurance company or other third party, it is possible that the third party's copy of my psychological records could possibly be released by the third party without the undersigned therapist's knowledge.

TREATMENT ALTERNATIVES

There are alternatives to therapy that can be provided by other mental health professionals. Alternative procedures may include prescription medication, family therapy, and other services provided by other psychologists, psychiatrists, social workers, counselors, and other mental health professionals. Each of these alternatives may have potential benefits and risks. If during the course of our work together, we discover problems outside the scope of my practice, I will assist you in obtaining a referral to an appropriate specialist for the necessary services.

APPOINTMENTS

Appointments are typically scheduled on a weekly basis and are 45-60 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call the office at 804-214-6363 at least **24 hours in advance**. If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this fee will not be covered by your insurance company.

DISCHARGE

Discharge occurs once the client and therapist agree that the treatment goals have been met or sufficient progress has been made and/or the client improves and no longer needs clinical services. Discharge may also result from missing two or more scheduled appointments, or not having an appointment scheduled for more than 30 days. The therapeutic relationship will be terminated and your file closed. Your case may be reopened at any time should you so choose, however you may be placed on a waiting list if there are other clients waiting to use your time slot.

FEES AND PAYMENT

I agree to provide counseling services in return for a fee of $150 for the initial session, $100 per 45 min. session, $125 per 60 min. session, or at my insurance provider contracted rate. Payment or co-payment for each session is collected prior to each session. Cash is an acceptable method of payment and I will provide a receipt for all fees paid. A sliding fee scale is available upon request and is based on household income level.

ACCOUNT BALANCES

It is the client's (guardian's) responsibility to know what their insurance will cover for each visit. Outpatient mental health benefits vary. Although your Therapist may be credentialed with your insurance company, this does not ensure your individual coverage. ***It is highly recommended that you call to verify your benefits in order to prevent unforeseen cost.*** Clients with self-pay balances are asked to pay their account balances to zero (0) prior to receiving further sessions. Clients who have questions about their bills or with any outstanding balances may contact my office to discuss a payment plan option. Clients must make payment arrangements prior to future appointments being made.

TESTIFYING IN COURT

Due to the nature of the therapeutic process and that it often involves making a full disclosure of many confidential and intimate matters, it is agreed that should there be legal proceedings, neither you or your attorney or anyone else acting on your behalf will call me to testify in court or at any proceedings nor will a disclosure of the psychotherapy records be requested. However, if I should receive a subpoena by the Court, you will be responsible for my individual hourly court fee ($300), which is applied for all professional time allocated for my services (e.g. travel time, paperwork time, etc.). In addition you will be asked to sign additional paperwork.

STATEMENT OF UNDERSTANDING

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will expire automatically as follows: I understand that my consent for release of information will be considered valid for twelve (12) months following the date below. I acknowledge that I voluntarily consent to the above conditions and that this consent form is valid during any related claims. I certify that I have read this form or that it has been read and explained to me in terms that I understand. My questions have been answered to my satisfaction, all blank spaces on the form have been completed, and all statements of which I do not approve have been stricken. By signing this form, I understand and agree with the terms and conditions of this form.

_____ _____

Client's Name (printed) Date

I declare that I am the legal guardian and/or managing conservator of the above-named child and grant permission for his/her psychological treatment.

Print Name: _____

_____ _____

Parent/Legal Guardian's Signature Date

_____ _____

Cheryl Outen, PhD, LPC, NCC Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____

Date of Birth:_____ Social Security Number: _____

I _____(client/legal guardian) hereby grant my permission for release of information relating to treatment of _____(client) both to and from the parties named:

Information Released:

_____ Social History

_____ Medical and Physical History

_____ Psychological Testing

_____ Progress Reports

_____ Psychiatric Evaluation

_____ Discharge Summary

_____ School Records

_____ Court Records

Other (Specify) _____

I, _____understand that this authorization may be withdrawn at any time in writing. This authorization will remain in effect 180 days after I complete treatment. Recipients of my information are forbidden from redisclosure without my specific written authorization. A file copy of this release is considered equivalent to the original.

Note: Your records may be released by the consent of your authorized representative, by court order, or as otherwise required or permitted by law. In addition you may request a copy of your records at any time.

_____ _____

Client Signature/ Guardian Signature Date

_____ _____

Cheryl Outen, PhD, LPC, NCC Date