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INFORMED CONSENT & AUTHORIZATION FOR THERAPY

PLEASE READ EACH OF THE FOLOWING SECTIONS AND INITIAL EACH SECTION AFTER YOU READ IT, THEN SIGN AND DATE ON THE FINAL PAGE WHERE INDICATED.

WELCOME TO MY SERVICES!

Krystle Rowe, LMFT is a licensed therapist doing business independently as a sole proprietor. It is important in beginning our professional counseling relationship for you to understand both its nature and limitations. Please review this document and feel free to ask any questions. The Informed Consent contains important information about my professional services, business policies, and the current legal and ethical requirements for marriage and family therapists.

As you become informed and aware of the policies and your responsibilities and rights, then you become a full participant in the therapeutic process and the accomplishment of your goals. The therapeutic relationship is unique in that it often feels like a friendship, however, it is a professional one that is regulated by state laws, codes of ethics, and standard business practices. The goal(s) of therapy will be determined together in the sessions, and the outcome will be a mutual responsibility. The commitment of the therapist and the client's trust in the therapeutic process are equal factors in achieving the stated goals and a positive outcome.

Your agreement with the business practices described below will be indicated by your initials throughout the document, and on the last page, your signature.

_____ (Initial Here)

Treatment Philosophy:

I believe in providing goal-oriented, solution-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-effective manner. You will take an active role in setting and achieving your treatment goals. Your commitment to this treatment approach is necessary for you to experience a successful outcome. During therapy, you may be asked to comply with treatment recommendations and/or homework. These recommendations are designed for treatment success; compliance with these recommendations is encouraged. If you ever have any questions about the nature of the treatment or anything else about your case, please don't hesitate to ask.

_____ (Initial Here)

Therapist Background and Information:

I am a Licensed Marriage and Family Therapist (CA MFCC# 50964) and have been licensed since December 2011, and practicing as a clinician since 2008. I obtained a Master of Science degree in Clinical Psychology with an emphasis in Marriage and Family Therapy from California State University, Fullerton and a Doctor of Philosophy degree from San Diego University for Integrative Studies. My work derives mainly out of a Cognitive Theory and Attachment Theory perspective. My specialties include work with couples, trauma, parenting and relationship issues. I am trained in E.M.D.R., Cognitive Processing Therapy and Emotionally Focused Therapy. I am certified in Prolonged Exposure Therapy, Positive Parenting Program, Nurturing Parenting Program, Hypnotherapy and the Trauma Resiliency Model. I am in good standing with the California Association of Marriage and Family Therapists.

_____ (Initial Here)

PAYMENT OF FEES

California law requires that all fees are established and agreed upon prior to beginning therapy.

The agreed upon fee is _____ per 50 minute session. My standard fee for services is \$100 per hour. Under special circumstances a sliding scale may be used. A conversation about special financial circumstances can be initiated with your therapist. Should your practitioner initiate a change in fee, you will be notified in writing and given adequate notice as defined by the California State Board of Behavioral Sciences.

In addition to weekly appointments, I charge this amount for other professional services you may need including each additional emergency clinical hour (whether in person or by phone) and preparation of records. Free of charge, I can provide you with an informal participation record which can be completed at the end of your session(s). A complementary participation record can be completed by your practitioner upon your initial enrollment. Please request this at the beginning of your first session (intake). If you become involved in legal proceedings that require my participation due to subpoena, you will be expected to pay for my professional time even if I am called to testify by another party.

Services that I do not provide include providing documentation for court, appearing in court (unless subpoenaed), conducting child custody evaluations, preparing materials for divorce proceeding, etc.

You will be expected to pay for each session at the time of the session. I accept cash, personal checks and credit cards. 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 payment. This may involve hiring a collection agency or going through small claims court. 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 client's treatment is his/her name, the nature of services provided, and the amount due. I may need to terminate treatment due to an unpaid balance and will provide more affordable outside referrals.

(Initial Here)

Cancellations & Missed Appointments:

Scheduled appointments are reserved especially for you. **To avoid being responsible for a cancellation fee of 50% of your assigned session cost, it is necessary to provide 24 hours notice by telephone** [no e-mails or text messages, please]. Repeated "No Show" appointments could result in a loss of future appointments. At that time, you would be referred to another provider, or in the case of insurance payers, to your insurance carrier for reassignment to another provider.

A current credit card number must be on file at all times, regardless of your preferred method of payment. Your card will not be charged if you choose to pay using another payment method at the time your payment is due. If credit is your preferred method of payment, your card will be charged at the end of each session for services rendered. At any time you may request an invoice for services rendered.

My signature hereby authorizes Krystle Rowe to charge my credit card (provided below) for the amount of any balance unpaid for 30 days or more. I am also authorizing Krystle Rowe to charge my card when I do not show up for my scheduled appointment or if I cancel in less than 24 hours notice. The charge for a "no show or late cancellation" is 50% of your full session fee, agreed upon in this document.

Name on Card: _____
MasterCard or Visa# _____ Security Code: _____
Expiration Date: _____ Zipcode of Billing Address: _____

(Initial Here)

MINORS AND PARENTS

Clients under 18 years of age who are not emancipated can consent to psychological services subject to the involvement of their parents or guardian unless the therapist determines that their involvement would be inappropriate. A client over 12 years of age may consent to psychological services if he or she is mature enough to participate intelligently in such services, and the minor client either would present a danger of serious physical or mental harm to him or herself or others, or is the alleged victim of incest or child abuse. In addition, clients over 12 years of age may consent to alcohol and drug treatment in some circumstances. However, un-emancipated patients under 18 years of age and their parents should be aware that the law may allow parents to examine their child's treatment records unless the therapist determines that access would have a detrimental effect on the professional relationship with the client, or to his or her physical safety or psychological well-being.

Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement, is also essential, it is usually my policy to request an agreement with minors (over 12 years of age) and their parents about access to information. This agreement provides that during treatment, the therapist will provide parents with only general information about the progress of the treatment, and the client's attendance at scheduled sessions. The therapist will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless the therapist believes that the child is in danger or is a danger to someone else, in which case, the therapist will notify the parents of his or her concern. Before giving parents any information, I will discuss the matter with the child, if possible, and try to handle any objections he or she may have.

(Initial Here)

EMERGENCY AND AFTER-HOURS CARE

I have a confidential voice mail that allows you to leave a message at any time. I will make every effort to return calls within 24 hours but cannot guarantee that the calls will be returned immediately. I am unable to provide 24-hour crisis service. If you have an emergency after hours, you agree to call 911 and/or go to the nearest emergency room. After these steps, you may call my office number at (909) 815-9553 and leave a message to notify your practitioner; your therapist will follow up with you upon notice.

(Initial Here)

CONFIDENTIALITY STATEMENT

It is understood that all the information between provider of treatment and patient is held in strict confidentiality. The client has the privilege of this confidence and is not bound to these limits, as is the professional therapist. All written and spoken material from any and all sessions are confidential unless you give written permission authorizing the release of all or part of the information to a specified person, persons, or agency, and/or if you introduce your therapy into a court case.

California law and professional ethics either mandate or allow therapists to break client confidentiality under certain circumstances. These are called "exceptions to confidentiality" and include situations in which the therapist has reasonable suspicion of any of the following:

1. The patient presents a physical danger to themselves, or to others.
2. An identifiable child is the victim of emotional, physical or sexual abuse, neglect or unjustified mental suffering.
3. An elder [anyone 65 years of age or older] or dependent adult is the victim of emotional, sexual or physical abuse, neglect, abandonment, forced isolation, or fiduciary abuse.

In addition, I understand in the latter three cases, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. The exceptions to confidentiality listed here are not a comprehensive list of exceptions. There are certain circumstances in which confidentiality is understood to be at risk of compromise, such as in the following instances:

1. In the event of a conjoint session including one or more other persons, the therapist will be responsible for the maintenance of confidential communications and records; however, the confidentiality will be contingent upon the compliance of all parties in the session.
2. The use of electronic communication such as fax, e-mail or text messaging may pose a compromise to confidentiality.
3. Insurance and 3rd party payers pose a compromise to confidentiality in that they require certain information for the processing of payments, and case management.

(Initial Here)

“No Secrets” Policy for Family Therapy and Couple Therapy

This written policy is intended to inform you, the participants in family therapy or couple therapy, that when I agree to work with a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek the authorization of all members of the treatment unit before I release confidential information to third parties. Also, if my records are subpoenaed, I will assert the psychotherapist-patient privilege on behalf of the patient (the treatment unit).

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless I am required by law to do so or unless I have your written authorization. In fact, since these sessions can and should be considered a part of the family or couple therapy, I would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit — that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgment as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow me to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For

instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

(Initial Here)

Release of Information for Third Parties:

I authorize release of information in the course of treatment, including diagnosis and treatment planning, to the professional referral source/insurance companies/3rd party payers for the purpose of payment of claims, certifications and case management, quality improvement and other purposes related to the benefits of my health plan.

(Initial Here)

RECORD KEEPING

Ethics, law and the standard of care all require professional therapists to maintain adequate records on their clients. It is your right to request and obtain access to your file and the complete contents therein. All requests must be made in writing. For further information please review the Written Authorizations & Consents to Release Health Information handout. Privacy is maintained and files are securely kept in locked cabinets.

HIPAA (Federal Health Insurance Portability and Accountability Act) ensures the confidentiality of all electronic transmission of information about the client. I am HIPAA compliant. Also, by initialing below you agree that you have been provided with a copy of the *Notice of Privacy Practices*.

(Initial Here)

RISKS ASSOCIATED WITH THERAPY

It is important to understand that while therapy is designed to be helpful, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, anger, etc. These feelings may carry over into your life and/or your current relationships, and may cause a disruption in your daily living. It is possible that the symptoms that brought you to treatment may increase in frequency and intensity before they get better. Please be aware that this is a normal response to talking about unresolved life experiences and will be worked on between you and your therapist. In addition, although improvement is the goal in therapy, there is no guarantee that this will occur.

Another risk involves the insurance companies' requirement of a diagnosis from the standard practice book DSM-IV-TR or DSM-V. This diagnosis is a short-hand description of the nature of the problem(s). It is important to understand that a diagnosis can become a permanent part of your record, and may have ramifications in terms of costs of insurance, obtaining long-term insurance, and possibly affecting employment.

(Initial Here)

TERMINATION OF TREATMENT

Professional ethics require that you work with only one therapist at a time for the same issues, therefore, it is necessary to terminate with one before beginning with another. If you begin therapy, it is important to know that you may terminate treatment at any time, and I will assist you in your termination process. Ideally, therapy ends when we agree that your treatment goals have been achieved. Although not an obligation, it is recommended you attend one additional session or phone consultation, after you have decided to terminate. I believe it is a beneficial closure for you and the therapeutic process and, if needed, I will attempt to ensure a smooth transition to another therapist by offering referrals.

I reserve the right to terminate therapy at my discretion. Reasons to terminate include, but are not limited, to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client is not making adequate progress in therapy, or client's needs are outside my scope of competence or practice. If it become apparent during the course of therapy that the presenting issues are outside the scope of the therapist's competence and training, then it is ethical at that time to refer the client to another professional with that competence.

All cases will be closed if inactive for more than 30 days, unless prior arrangements are made between the client and the therapist. By signing this you acknowledge and agree it is the client's responsibility to maintain scheduling of regular appointments. The therapist may or may not formally notify you of your case closure. This therapist observes an open-door policy, which means that you may reinstate treatment at a later date upon notifying this clinician of your intent to return to treatment.

_____ (Initial Here)

CONSENT FOR TREATMENT

I understand that by having initialed the above sections and by signing below, that I am agreeing to and freely acknowledging my willingness to undergo treatment that is deemed appropriate and in accordance with this Informed Consent.

I also accept total financial responsibility for payment of all fees and services, regardless of insurance coverage and/or 3rd party payers.

Client Signature (1)

Date

Print Name of Client (1)

Client Signature (2)

Date

Print Name of Client (2)