INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES

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Disclosure Statement

This is a statement of your rights and responsibilities for our therapeutic relationship. The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. This document is designed to inform you of my professional credentials, types of services offered, fee schedule, and therapeutic orientation and style. You will receive this copy for your records and I will keep the signature pages for my records. Please read this carefully and if you have questions that are not covered here or want further clarification, please ask me when we discuss this statement during the session.

Education & Credentials

I received a Masters of Counseling (MS) in December 2021 from John Brown University in Arkansas, and was initially licensed in the state of Arkansas in March 2022. I have been providing psychotherapy since that time. I am licensed by the state of Florida (MH25813) and Arkansas (P2405022). I work with clients struggling with anxiety, depression, trauma, disordered eating, and adjustment disorders.

What to Expect from Counseling

Psychotherapy is a collaboration between a professional clinician and you, the client. Therapy is an investment of time, money, and energy into your personal growth, so please feel free to ask questions about our work together. I am here to assist you in your process. You will get out of counseling what you invest into it. For your emotional safety, it is unethical for me, your counselor, to engage in any other relationship with you outside of this professional, therapeutic alliance while we are working together and sometimes after we have finished our therapeutic work together.

Services Offered & Length of Session

I provide individual psychotherapy and relational counseling. Services will be rendered in a professional manner consistent with ethical standards. It is impossible to guarantee any specific results regarding your counseling goals, as the outcome is dependent on your work as well as mine. Sessions are 50 minutes in duration. We will schedule our sessions by mutual agreement.

If you are unable to keep an appointment please call with at least 24 hours to cancel or reschedule. See cancellation policy below.

Counseling Process & Approach

I use Acceptance and Commitment Therapy (ACT), Cognitive Behavioral Therapy (CBT), Interpersonal Therapy (IPT), and Dialectical Behavioral Therapy (DBT) skills. These theoretical orientations and their accompanying techniques are empirically-based and may sometimes cause some discomfort before relief. As a Christian, I am also able to offer to integrate Christian faith into treatment according to your discretion. If you would like to involve your own faith into treatment, you are welcome to bring as much (or as little) of your faith into session as you choose, and I will follow your lead.

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Risks and Benefits

Counseling has both risks and benefits. Talking about difficult thoughts or feelings may be painful, making changes to your status quo may be uncomfortable, and uncovering and addressing factors underlying your presenting symptoms may cause symptoms to get worse before they get better. However, building resilience, tools and skills, gaining insight, and working through challenges often results in benefits such as solutions to specific problems, increased life satisfaction, improved self-confidence, increased capacity to effectively manage emotions and stress, and improved interpersonal relationships. Your process will be uniquely your own; there is no guarantee of what risks or benefits you will encounter.

Confidentiality

All information shared in session is confidential, with these few exceptions. Please read these exceptions carefully and discuss any questions or concerns you have with me.
(1) For case consultation purposes, I may consult with other licensed therapists, who are required to keep client information confidential.
(2) If I suspect, or if you disclose information about, abuse or neglect of a child, elderly person, or a disabled or otherwise dependent person, I am required by law to report it to the appropriate authorities.
(3) If I believe you are in danger of harming yourself or another person, I must act to protect you and/or others. If you believe you intend to injure another person, I am required by law to inform that person and law enforcement.
(4) If I believe you need to be involuntarily hospitalized for a debilitating mental illness or alcoholism.
(5) If I am ordered by a court to release information as part of a legal involvement, I must comply. If that happens, I will release as little information as necessary to satisfy the court order and strive to do so in a way that protects your privacy as much as possible. A court order may require disclosure of your PHI for several reasons not limited to the following: if a civil, criminal, or disciplinary action arises from a complaint filed on your behalf against a mental health professional; if your mental or emotional condition is presented as a legal defense.
(6) Information which may jeopardize my safety will not be kept confidential.
(7) Allegations of sexual misconduct by a Florida licensed health professional must be reported to the licensure board.
(8) In the event of a medical emergency on your part, emergency personnel may have to be provided with some of your information.
(9) If you bring a complaint against me with the Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling or the Arkansas Board of Examiners in Counseling, information will be released.
(10) If you disclose HIV infection without informing your sexual or needle-sharing partner(s), I am required to report this information to the appropriate authorities.
(11) In some circumstances, your PHI may be disclosed without your consent to: public health authorities, law enforcement officials, correctional institutions (regarding inmates), federal officials for lawful military or intelligence activities, coroners, medical examiners and funeral directors, and other entities when required by law.

In addition to the previously stated confidentiality exceptions, the following confidentiality exceptions also apply to children and adolescents. (1) General periodic updates on your progress to parents/guardians (specifics of what is discussed in session will be kept confidential). (2) If you engage in risky behavior that endangers your safety or the safety of others, I will notify your parents/guardians. (3) Your parents/guardians do legally have the right to request your PHI records. I discourage that, and most parents/guardians refrain from doing so. If I need to disclose information to your parents/guardians, I will do my best to discuss it with you first.

If I receive a request for your PHI without your prior written consent, I will contact you and ask if you wish to authorize disclosure. If you refuse or you cannot be contacted, your PHI will not be disclosed.

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Communication

Because email, phone calls, and text messaging are not considered strictly confidential forms of communication due to the technology involved, I do not encourage the exchange of clinical information via these tools. When you communicate with me using unencrypted email, texts, or via phone messages, you assume the responsibility of the risk that your information and identity may be intercepted. If you choose to communicate with me using email or SMS/text messaging, you are advised to use personal email and SMS/MMS addresses rather than those associated with your work accounts. With your consent, we will send email or text reminders of your appointments for your convenience, though it still remains your responsibility to remember your appointments.

If we cross paths or see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Use of Third Party Software, Applications, and Electronic Communication

I use a number of software, web-based, and electronic applications created and administered by third party providers. These include but are not limited to TherapyNotes, Doxy.Me, and Google/Google Workspace. Additionally, third party applications may be implemented by our practice without any additional disclosure to you as the client at any point in the future. While I have secured a “Business Associate Agreement” (BAA) from each of these service providers, I cannot ultimately guarantee their compliance with HIPAA and other regulations. As part of signing this document and receiving service from me, you exempt me and Beachside Counseling and Wellness, LLC from liability or blame for any privacy violations that occur due to any action on the part of these vendors.

Insurance Reimbursement & Diagnosis

Should you wish to use an insurance policy for counseling services, it is your responsibility to contact your insurance company to inquire about specific coverage for out-of-network benefits for mental health services. Please note that most insurance companies require a psychiatric diagnosis in order to reimburse for mental health counseling. I can provide a superbill for you to mail to your insurance company for possible reimbursement. Any diagnosis made will become part of your permanent insurance records.

Counseling Fee

Payment is due at each session. Regardless of insurance, you agree that you, or the financially responsible party if other than the client, are responsible for payment of all fees for services rendered. Cash, personal checks, Visa, Mastercard, American Express, and Discover are acceptable methods of payment and I will provide a receipt for all fees paid. Private pay rates are as follows: $155 for individual intake sessions and follow up sessions, $175 for relational intake sessions and follow up sessions, and a pro-rated rate of $175 for phone consultations longer than 5 minutes.

Cancellation and Rescheduling Policy

You will be charged $100 for missed appointments or failing to cancel or reschedule your appointment at least 24 hours ahead of your scheduled appointment time. Please understand that your insurance will not reimburse you for any portion of a missed appointment and you are responsible for the full fee. If you arrive late for your appointment, we will use whatever time you have left within the scheduled 50-minute session.

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Emergencies

If you are experiencing a life-threatening emergency, call 911 or go to your nearest emergency room. I do not provide crisis or emergency services, and nor does Beachside Counseling and Wellness. If you feel the need to speak with me before your next scheduled appointment, you may call the office at 321-327-3793, and I will do my best to return your call during regular office hours (9:00 am-5:00 pm, Monday through Thursday). After hours and on weekends, you may leave a message with the answering service at Beachside Counseling and Wellness, and they will attempt to contact me. If I cannot be reached and return your call within an hour, they will give you the option to have another licensed clinician to return your call. These clinicians are bound by the same legal, ethical, and privacy guidelines as I am.

Complaint Procedures

I adhere to the highest ethical and professional standards. If you are dissatisfied with any aspect of the counseling process, please inform me so we can determine if our work together can be more efficient and effective or if referral is appropriate. If you think I have treated you unfairly or unethically, and we cannot resolve the problem, please contact: Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling at 850-245-4292 or Department of Health, Board of Mental Health Professions 4052 Bald Cypress Way, Bin C-08, Tallahassee, FL 32399-3258.

Ending the Therapeutic Relationship

The therapeutic relationship is designed to be for a season, so it is helpful to begin knowing that there will eventually be an end. Therapy may come to an end through the natural progression of therapy and completion of goals. You are free to end our counseling relationship at any time and for any reason. If you feel unhappy with me, I invite you to bring it up in session first, as working through the difficulty together can have tremendous therapeutic benefits. If you still wish to discontinue counseling for that or any other reason, I am happy to provide you with referrals to other mental health providers in the community upon your request. If through our work together I determine that your needs fall outside the scope of my practice, training, and/or experience, it is my ethical responsibility to provide you with referrals to providers who can better meet your needs.

By signing below, I, the client or client's parent/guardian, am agreeing that I have read, understood and agree to the items continued in this document; that I voluntarily consent to proceed with psychotherapy services based on this information; and that I understand I may stop treatment at any time.

_____ _____

Your signature Date

_____ _____

Parent/Guardian signature (if client is a minor) Date