

THERAPY CONSENT, POLICIES, & AGREEMENT

PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific issue or concern. Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: For clients to reach their therapeutic goals, it is essential they complete tasks when assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than you expect. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve the desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not have been originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaboratively identify your therapeutic goals. Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed, and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 50 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss what the next steps are and how often therapy sessions will occur.

APPOINTMENTS AND CANCELLATIONS: You are responsible for attending each appointment and agree to adhere to the following policy: *If you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment in advance of 24 hours of the scheduled appointment time. If you cancel or reschedule more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time. If you no-show for your scheduled appointment or do not cancel/reschedule with 24 hours' notice, you will be charged the full session fee.*

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events.

FEES: The fee for each **50-minute** therapy session is **\$200**. Payment is due at the time of service. Acceptable forms of payment are exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus **\$25.00** for any returned check), credit/debit card through PayPal. If a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the "Appointments and Cancellations" policy above.

The clinician reserves the right to terminate the counseling relationship if more than **3 sessions** are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed separately and are due within 30 days of receipt of the invoice.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of **\$1000.00** to include travel time, court time, preparing documents, etc.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records; the cost is **\$2.00** per page. Payment for your medical records will be due prior to or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Office hours are from Mon/Wed 10am-8pm, and Tue/Thu 2pm-8pm. If you need to contact the clinician for any reason, please call (732) 778-2774, leave a voicemail, and a return call will be made within 24 hours (or as soon as possible) In case of an emergency, you can access emergency assistance by calling the Psychiatric Emergency Screening Service (P.E.S.S) at Monmouth Medical Center at (732) 923-6999, or the National Suicide Prevention Lifeline at 1-800-273-8255.

PART II: CONFIDENTIALITY:

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *except* for the following limitations:

- **Child Abuse:** Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse:** Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm:** Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others:** Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas:** If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health:** A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities:** To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death:** To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

- **Victim of a Crime:** Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Written Request:** Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual “psychotherapy/process notes”, except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes:** In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e., your signature on the “Therapy Consent & Agreement” that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & “No Secret” Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a “secret” that is detrimental to couple’s therapy goal. If one partner requests that I keep a “secret” in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **Dual Relationships & Public:** Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (i.e. social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media:** No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical records.
- **Electronic Communication:** **If you need to contact me outside of our sessions, please do so via phone.**
 - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential.** Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client’s phone.
 - **Do not use e-mail for emergencies.** In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **The e-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

PART III: HEALTH INSURANCE

I am an **out-of-network provider** which means I **do not** participate with any insurance companies. If you have out-of-network benefits with your insurance company, I can provide you with a detailed invoice with all the proper codes needed by the insurance company to issue reimbursement to you based on your plans’ benefits structure. In some cases, I may be able to submit the insurance claim for you. Oftentimes in this case the insurance company may send the payment to the subscriber of that insurance instead of the provider. You would be required to sign over that check or issue one for that amount from your own bank account. (This is in addition to the co-insurance you are responsible for).

PART III: REASONS I DO NOT ACCEPT INSURANCE

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require “preauthorization” before you can receive services. This means you must call the company and justify why you are seeking therapeutic services for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company’s list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.

- **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the therapist justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.

- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require clinicians to give a mental health diagnosis (i.e., “major depression” or “obsessive-compulsive disorder”) for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance.
2. Company (mis)control of information when claims are processed.
3. Loss of confidentiality due to the increased number of people handling claims.
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (i.e. divorce court, family law, criminal, etc.).

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couple’s therapy.

Why Clinicians Do Not Take Insurance: These involve enhanced quality of care and other advantages:

1. You are in control of your care, including choosing your therapist, length of treatment, etc.
2. Increased privacy and confidentiality (except for limits of confidentiality).
3. Not having a mental health disorder diagnosis on your medical record.
4. Consulting with me on non-psychiatric issues that are important to you that aren’t billable by insurance, such as learning how to cope with life changes, gaining more effective communication techniques for your relationships, increasing personal insight, and developing healthy new skills.

After reading my position on why I don’t accept health insurance, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you.

EMERGENCY CONTACT:

It is necessary that **Space Counseling/Scott Pace, LLC** has someone to contact on your behalf. In case of an emergency who should we contact?

Full Name	Relationship	Phone Number(s)
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Please check here that you agree and sign below. Thank you.

I agree to allow **Space Counseling/Scott Pace, LLC** to contact my emergency contact on my behalf in the case of emergency

Signature	Date
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PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Scott Pace**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by

the agreement and policies listed in this consent. I authorize **Scott Pace** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to Scott Pace of Space Counseling. I acknowledge that I am financially responsible for payment whether covered by insurance. I understand, if fees are not covered by insurance, Scott Pace of Space Counseling may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Scott Pace to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Scott Pace** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the “Therapy Agreement, Policies and Consent” for your records.

Printed Name of Minor Child	DOB	Date

Witness – Scott Pace

Date

CLIENT COPY

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Scott Pace**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Scott Pace** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to Scott Pace of Space Counseling. I acknowledge that I am financially responsible for payment whether covered by insurance. I understand, if fees are not covered by insurance, **Scott Pace of Space Counseling** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

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