Openings Counseling LLC

Client Informed Consent

Congratulations on taking the next step towards healing and wholeness! Your first appointment will take approximately 75 minutes. This document is intended to inform you of my policies, state and federal laws, and your rights. If you have any questions regarding the information presented, please feel free to ask.

PART I: MY PERSONAL, PROFESSIONAL INFORMATION

My Qualifications:

I have a Master of Science degree in Marriage & Family Therapy from Central Connecticut State University, and have worked in a community mental health setting since 2011. Currently, I am licensed as a Marriage & Family Therapist (LMFT). Additionally, I have three levels of training in the Internal Family Systems Model of psychotherapy.

My Primary Therapeutic Approach and Philosophy:

My approach to therapy is grounded in the Internal Family Systems Model, and Solution Focused Therapy, informed by the view that each of us is capable of wellness and wholeness. I believe that everyone can develop the tools and skills necessary for their own healing.

By providing a safe, nurturing environment for individuals, couples, and families to identify issues that block them from living their full potential, we can open to new possibilities. A collaborative therapeutic process will support you in developing insight and understanding, finding creative strategies, shifting old beliefs and behaviors that can get in the way of making lasting change. I can help you explore, process and release unresolved emotional experiences of hurt, anger, and fear that keep you from leading a balanced life.

My goal is to build on your strengths, empower you and help you identify and work towards a healthy relationship with yourself and others. Expect to laugh, cry and grow. You can begin again and discover the life you have imagined.

PART II: THE THERAPEUTIC PROCESS

Client Rights: Therapy can be a safe place to discuss your feelings, identify life goals, and work on personal growth. However, there can be a risk to therapy as well; it can bring about painful feelings or memories which may lead to an increase in the symptoms that brought you to therapy initially. This is usually temporary and can often be resolved by continuing to work with those feelings or memories, or changing the course of therapy in a way that feels more 'safe' to you.

Code of Ethics and Privileged Communication: I am required to abide by the professional practice standards for marriage & family therapists and Connecticut Law. I am also required to abide by the Code of Ethics for Marriage & Family Therapists for my professional association, American Association of Marriage and Family

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Therapy (AAMFT). An electronic copy of this code is available at: http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx.

Confidentiality: I do not disclose client confidences and information to any third party without your written consent or waiver except when mandated or permitted by law. The information shared in the therapy setting is confidential under law with certain limitations. State law mandates that in certain situations I report to the appropriate authorities information obtained during therapy to other persons or agencies – without your permission. Such circumstances:

- Mandated reporting of child abuse or neglect.
- Mandated reporting of elder abuse or neglect.
- Harm to yourself or a 3rd party; including threats of suicide or homicide.
- Written consent to release personal information.
- Court orders according to legal requirements and MFT ethical guidelines.

Collection of overdue accounts: The use of collection agencies or the court system would require that I disclose some information about my professional services. The information released in such a case would involve the client's name, dates and types of services rendered, amounts due and other relevant financial data.

Clinical Supervision: To enhance the quality of treatment services, other mental health professionals are periodically consulted regarding specific cases; identifying information of clients is kept confidential. If necessary, they also may provide emergency coverage during my absence. These professionals are bound by ethical and legal standards regarding confidentiality, and information will not be used for any public or media purpose. If this arrangement raises concerns for you or violates your sense of privacy, please discuss this with me.

You have the right to end therapy at any time: Therapy termination can sometimes be the result of misinterpretation, miscommunications, and the painfulness of the material being dealt with. Ending therapy will usually be agreed upon mutually, but you are free to leave at any time without any moral, legal, or financial obligations other than those already accrued. Should you decide between sessions to withdraw from therapy, it is asked that you attend one more session to discuss your reasons prior to making a final decision. If you decide to terminate, yet desire to continue therapy elsewhere, I will be happy to provide you with names of other qualified therapists.

If, at any point, I determine that your circumstances are beyond my ability, training, or scope of practice or I come to believe that therapy is not effective, I may refer you to a more appropriate resource.

PART III: ADMINISTRATIVE POLICIES AND PROCEDURES

Office Information : Voice mail is utilized which is screened during the workday. Although my goal is to return calls as soon as possible, all calls will be returned within 24-48 hours, unless otherwise notified.

Crisis Information: Persons who require frequent crisis intervention or hospitalization for major mental illness where symptoms include frequent suicide attempts, homicidal ideation, and psychotic thought processes such as auditory or visual hallucinations will only be accepted if client is in active treatment with a psychiatrist. Otherwise, referral options will be discussed. Weekend and holiday coverage are provided on a limited basis. If necessary, vacation coverage is arranged through an agreement with each individual client.

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Emergency situations: This practice cannot provide 24-hour emergency service. If an emergency arises outside of 10am – 6pm Monday and Friday business hours, you have several options; Dial 911 for immediate attention; Call the Capitol Region Mental Health Center (500 Vine St. Hartford), a 24/7 crisis and referral hotline, at (860) 297-0999; or Go to your nearest emergency room or urgent care facility.

Missed Appointments: If the cancellation is not received within 24 hours of the scheduled appointment time you will be charged the full session fee for the time I have reserved for you. PLEASE NOTE: If there are numerous missed or cancelled sessions, with notice or without, this will be discussed during the following therapy session for solutions which may, in rare cases, include the termination of therapy or referral to another qualified therapist.

Late Appointment Arrivals: I understand that sometimes circumstances arise that may make you late for an appointment. *If you are going to be more than 10 minutes late for your scheduled time, please notify me at your earliest convenience via phone call or text message.* **PLEASE NOTE:** To be respectful of the person scheduled after you, if you are late for your scheduled appointment time we will still need to end our session at the normal time (i.e. if your scheduled appointment time was 1 pm, we will still need to end at 1:50 pm).

Phone Calls: If it is necessary to provide frequent intervention by phone, calls will be billed at the usual hourly rate of $75 per 50 minute session.

Court Fees: $225 per hour (paid in advance). This includes preparation, travel and waiting times. There will be a cancellation fee of $225 for court appearances cancelled less than 48 hours prior to the scheduled time.

Annual Fee Increase: All session fees will increase by $5 on January 1 of each year, in order to accommodate cost of living and business expense increases.

Special requests for letters to employers, attorneys, physicians, etc. will be billed at $75 per hour of preparation, or at prorated rate for anticipated preparation time.

Unpaid Balances: All fees are payable at each session. Please notify me when financial circumstances make it difficult to pay your bill on a weekly basis. Large balances may result in straining our relationship and the work we do together. All balances due after 30 days will be subject to a 1.5% monthly charge (18% annually).

Collection Policy : Any unpaid balance over 90 days, without prior authorization, will be turned over to a collection agency. In the event that therapy is ended and a bill is left unpaid, your name, address, and phone number will be given to a collection agency in order to collect payment.

Social Media Policy : Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions regarding social media, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

EMAIL : I prefer using email only to arrange or modify appointments, unless we have contracted to engage in therapeutic email exchanges. Keep in mind most forms of email are not as secure or confidential.
FRIENDING: I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

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Agreement to Informed Consent Terms

My signature below indicates that I have read and understood the above information including: *Please Initial*

_____ Client rights, confidentiality and its legal rights and exceptions, emergency situations, clinical supervision, coordination of treatment, client contact, office policies and procedures, social media policy and that I have received and read a copy of the notice of Privacy Practices.

_____ I understand the financial agreements I agree to be responsible for the full payment of fees for services rendered at the beginning of each appointment.

_____ I hereby consent to treatment with Susan Scott, MS, LMFT of Openings Counseling, LLC.

_____ I understand that no promises are being made to me regarding results of treatment and that my therapeutic success will be most significantly impacted by my commitment to the process.

_____ Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

Client Contact Information

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

I would like to be contacted by: □ Cell □ Text □ Email □ Home phone □ Work phone
□ Y □ N I may leave a message on the answering machine or voice mail.
□ Y □ N I may leave a message with another person (spouse, child, receptionist).

Notice of Privacy Practice and Clients' Rights:

___ I have received and read a document copy of the notice of Privacy Practice

Informed Consent for Treatment of Minors:

I consent that _____ may be treated as a client by Susan Scott MS, LMFT

Parent's Signature _____ Date _____

Parent's Signature _____ Date _____

Signature _____ Date _____

Therapist Signature_____ Date _____

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