Theresa M Cukierski, LPCC-S
INFORMED CONSENT

Please read the following document carefully to understand practice policies

Psychotherapy Services
Therapy services are offered to help you better understand your situation, change your behavior, or move toward resolving your difficulties. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life.

However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. **There are no guarantees about what will happen. Therefore, it requires an active effort on your part for positive changes to occur. To be successful, you will need to work on the things we discuss outside of our sessions.**

The first 2-4 sessions will involve a comprehensive assessment of your needs, frequency of treatment, and therapeutic goals. If you have questions about my procedures, we should discuss them as they arise.

Having a positive and trusting rapport with your therapist is essential in reaching therapeutic goals. Not every client connects well with every therapist. If at any time you have concerns, or determine that we are not a good fit, please do not hesitate to address this in session. I will be sure to provide you with referrals to another practice that may be more suited to meet your needs. **Similarly, I reserve the right to terminate services if I determine that your needs are outside my scope of practice, there is no longer a therapeutic benefit, or for non-payment of services.**

Appointments, Cancelations, and Contacting the office.
Each session will be approximately 50-60 minutes in length. Every effort will be made to start and end your appointment at the scheduled time. Please note, **once an appointment hour is scheduled, it is assigned to you and you alone.** If circumstances arise where you must cancel or reschedule, I ask that you **provide notice at least 12 hours in advance of the scheduled time, or you will be charged for the missed appointment using the credit card kept on file.** You will not be charged for a missed appointment due to poor weather conditions, illness or other urgent medical needs, or legal requirements.

If you are 20minutes late for a scheduled appointment, and fail to notify the office, the appointment will be considered cancelled and the above cancellation policy will be applied. In the event of 3 or more appointments being missed or cancelled late, we will

discuss scheduling of future appointments, treatment goals, and possibly termination of services.

I am a sole practitioner at this private practice. This does not allow me to always answer my phone during business hours. If I do not answer the phone, I am typically with a client, out of the office, or otherwise unavailable. Please leave me a message and I will do my very best to respond to you as quickly as possible, or within one to two business for non-urgent matters. Current clients will be notified during session of upcoming out of town or vacation travel plans.

I may also be reached via E-mail and Text Messaging. Please note that once you have initiated contact through electronics, you have consented to the risks of confidentiality as text messaging and E-mail are not always secure forms of communication. With permission or request, I will contact you electronically (verbal, written, or initiated by you).

If you believe you have an emergency, or are unable to keep yourself safe, please contact 911 or go to a hospital's emergency room.

Professional Fees and Insurance

When using your insurance company as a method of payment, the standard fee for the Diagnostic Assessment is $150.00 and each subsequent session is $130.00. However, self-paying clients are discounted at $130.00 for the Diagnostic Assessment, and $110.00 for the appointments thereafter. Enrolled college students are given an additional discount of $90.00 for psychotherapy sessions. Proof of enrollment is required. Self-paying clients are also offered a 15% discount Advanced Payment Option.

Insurance company contracts may have preset fees that I am required to accept if I have contracted with them as an "in-network provider." It is important for you to evaluate what resources you have available to pay for your treatment so that we may establish attainable goals and you can feel confident in knowing how much of your treatment is covered. If I am not an in-network provider for your insurance plan and am unable to submit a claim directly to them, I will provide you with the necessary paperwork to submit to your insurance company for reimbursement.

Managed Health Care plans such as HMO's and PPO's often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

I ask that payment or insurance co-pays are paid at the beginning of each session. Payment is preferred by check or cash. However, I am able to accept Visa, MasterCard, Discover, & American Express **with an applicable service fee *(swiped 2.7% keyed 3.5%***

+ $0.15). Any checks that are returned are subject to an additional fee to cover the bank charges. If you do not pay the amounts owed, I reserve the right to use a collection agency to secure payment.

An active credit card on file is required at the time the initial appointment is scheduled and throughout the time your case is considered open at this practice. This card will be used for a late cancelation, missed appointment (No Call/No Show), payments/co-payments (if requested), and overdue balances. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. In the event that an account is overdue (60 days) and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed.

This practice may send an invoice to the home address of a client indicating the amount due, the date it is due by, and the last four digits of the credit card held on file that will be charged if payment is not rendered. Under most circumstances, I am willing to establish payment plans.

Court Action/Legal Fees

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify. In the event of a subpoena being issued or requested by you or your legal representative to appear in court or provide a written report, the fee will be prorated based upon a $100.00 per hour fee. Time spent in court testimony, at court, in depositions, waiting for a deposition or other case related subpoenaed meetings and case file preparation time shall be charged to the requesting party or their attorney at the above hourly rate of $100.00 per hour. If the Court, Children's Protective Services, or other case-related entity requests or subpoenas this counselor's appearance, the parties responsible for the fees, shall pay all fees related to the counselor's time to appear and prepare.

Professional Reference

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained securely both in your paper chart and TherapyNotes.com. Therapynotes.com is a secure and HIPPA compliant record and billing software. I keep brief records noting your reasons for seeking treatment, a description of the ways in which your problem affects your life, your diagnosis and treatment plan and progress towards your treatment goals. Except in usual circumstances, you have a right to review these records or request a copy. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I therefore recommend that you initially review them with me or have them forwarded to another mental health professional, so you can discuss the contents. A copy must be requested in writing.

Confidentiality
Your verbal communication and clinical records are strictly confidential except for: a. Information shared with your insurance company to process your claims (diagnosis and dates of service); b. Information you and/or your child or children report about physical abuse, sexual abuse or elder abuse; then, by Ohio State Law, I am obligated to report this to the Ohio Department of Job and Family Services; c. When a Release of Information form has been signed to have specific information shared; d. If you provide information that informs me that you are in danger of harming yourself or others; e. Information necessary for case supervision or consultation; f. When required by law.

Electronic Communication
Electronic messages (emails, text messages, etc.) are vulnerable to breaches of privacy, despite standard safeguards which are outside my control. Therefore, if you decide to share information with me through email or text you assume the risk for this communication being intercepted by a third party. Further, I am not responsible for safeguarding information once it has been delivered to you. By signing this consent, you agree to these conditions.

Text messages should be limited to scheduling purposes only. I do not provide distance counseling.

Parents and Minors
Parents/Guardians must consent to treatment for minors. The minor has a right to privacy within the counseling sessions and it is often crucial to developing a trusting and a healing environment with your child. However, parental involvement in the process is often essential to facilitate change and healing. For clients, age 14-17 years old, I ask for an agreement with the client's parents to allow privacy to be honored. However, request to share general information about the client's diagnosis, treatment, progress and attendance are acceptable. Other information will require a discussion with the minor first before giving parents any information, unless I determine there is a concern for the minor's safety.

Other Rights
If you are unhappy with therapy, or feel the need to terminate therapy, I hope you will talk with me about your concerns. I will respond to your concerns with care and respect. You may also request that I refer you to another therapist. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to a professional and therapeutic relationship. To preserve this relationship, it is imperative that I do not have any other type of relationship with you (friendship or otherwise).

Acknowledgment of Informed Consent to Treatment

The undersigned voluntarily agrees to receive mental health assessment, care, treatment or services and authorizes Theresa M Cukierski, LPCC-S to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment or services that I receive through Theresa M Cukierski, LPCC-S at any time. I also understand that there are no guarantees that treatment will be successful.

By signing this Client Information and Acknowledgment of Informed Consent to Treatment form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and agree to abide by its terms and conditions. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

_____ _____
Theresa M Cukierski, LPCC-S Date

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s)_____Date_____

_____Patient/Client Refuses to Acknowledge Receipt of the above:

_____ _____
Signature of Staff Member **Date**