Client name: _______________________________ Client D.O.B.: ______________________________

OHIO FAMILY COUNSELING
AND CONSULTATION, LLC

Ohio Family Counseling and Consultation, LLC
550 Main Street
P.O. Box 1311
Coshocton, Oh 43812
740-291-373

Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts himself/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

Client name: ________________________________ Client D.O.B.: _______________________________

OHIO FAMILY COUNSELING
AND CONSULTATION, LLC

5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. Other circumstances outlined in the Privacy Practices

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we 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.

I understand Ohio Family Counseling and Consultation, LLC is a "Person-Centered" agency that puts me in control of the development, monitoring and evaluation of my individualized service plan. I further acknowledge that all information divulged by me in counseling sessions is confidential information and will be retained and held confidential by Ohio Family Counseling and Consultation, LLC with the exception of those noted in the "Notices of Privacy Practices" (HIPAA) policy.

I understand that I will not be required to pay for services provided by Ohio Family Counseling and Consultation, LLC if I am enrolled in the Ohio Medicaid or Dual Ohio Medicaid/Medicare.

If I am not covered by these insurance programs, then I may be responsible for all or a portion of the costs for services rendered to me by Ohio Family Counseling and Consultation, LLC in accordance with the agency's rate schedule.

I further acknowledge that in the event I do not pay the applicable fees for services rendered to me that legal action may be taken including divulging to Ohio Family Counseling and Consultation, LLC's attorneys and courts in the local, state, and federal systems, the fact that I do owe an account Ohio Family Counseling and Consultation, LLC, the amount owed on the account, the date(s) services were rendered and the amounts of time involved in rendering said services to its attorneys and courts in the local, state, and federal systems for the purpose of collecting said debt. I understand my personal obligation and agree to pay within thirty days after receiving an invoice from Ohio Family Counseling and Consultation, LLC.

I understand that insurance companies will not pay for CPST services and I may have to pay for this service if offered.

Client name: ________________________________ Client D.O.B.: ______________________________

OHIO FAMILY COUNSELING
AND CONSULTATION, LLC

I agree to contact Ohio Family Counseling and Consultation, LLC if my insurance coverage changes in any way.
I agree to allow Ohio Counseling and Consultation, LLC to contact me at a later date to obtain my input on the quality of the services received at Ohio Family Counseling and Consultation, LLC.
I authorize Ohio Family Counseling and Consultation, LLC to accept payment from any and all third-party payers.
I acknowledge that I have received a copy of Ohio Family Counseling and Consultation, LLC's Policy and Procedure on Client Rights and Grievances and on Privacy Practices (HIPAA).

As of January 1, 2021, the practice fees are as follows:
$150 Psychiatric Diagnostic Assessment
$125 Psychotherapy - 60 minutes
$100 Psychotherapy - 45 minutes
$75 Psychotherapy - 30 minutes
$150 Psychotherapy for crisis 30-74 minutes
$125 Family Psychotherapy - 50 minutes
$100 Multi-family group psychotherapy - 45 minutes
$50 Group Psychotherapy - 45 minutes
$25 Alcohol/substance abuse assessment and intervention - 15-30 minutes
$25 Alcohol/substance abuse assessment and intervention - greater than 30 minutes
$40 Community Psychiatric Supportive Treatment - 15 minutes
$20 Group Community Psychiatric Supportive Treatment - 15 minutes
$25 Psychosocial Rehabilitation - 15 minutes
$40 Psychosocial rehabilitation for crisis - 15 minutes
$35 Therapeutic Behavioral Services - in office - 15 minutes
$45 Therapeutic Behavioral Services - in community - 15 minutes
$10 Group Therapeutic Behavioral Services - 15 minutes
$50 Therapeutic Behavioral Services for crisis - in community - 15 minutes
$40 Therapeutic Behavioral Services for crisis - in office - 15 minutes
$20 Interactive Complexity add-on
$25 returned payment fee
$25 Completion of Documentation such as SSDI, FMLA, or other
$500 per hour per staff member – court appearance fee (from the time of departure from office to return to office)

Client name: ______________________________ Client D.O.B.: _____________________________

OHIO FAMILY COUNSELING
AND CONSULTATION, LLC

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider may engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLE PRACTICE SERVICE

Telehealth by Simple Practice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by Simple Practice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Simple Practice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by Simple Practice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Simple Practice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by Simple Practice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).

Client name: ________________________________ Client D.O.B.: _______________________________

OHIO FAMILY COUNSELING
AND CONSULTATION, LLC

· That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

By signing below, I am agreeing that I have read, understand, and agree to the items contained in the document.

Signature: _________________________________ Relationship to Client: __________________

Name:_____________________________________ Date: _________________________________