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Informed Consent For Psychotherapy Treatment
Updated 11/6/2020

Welcome to my practice. Here is some essential information about my psychotherapy practice. Please read and sign at the bottom to indicate that you have reviewed and understand this information. Please also initial where indicated. Please let me know if you have any questions.

Length and Frequency of treatment: Psychotherapy typically involves regular sessions, usually 45-55 minutes in length, at least once a week. However, duration and frequency depend on the nature of your issues and individual needs. If you choose to enter psychotherapy with me, please be aware that the process is a rewarding one that requires work and commitment on both of our parts. Regular attendance is a key ingredient to the success of our work together.

Psychotherapy has been shown to have many benefits. It often leads to better relationships, solutions to specific problems and significant reduction in feelings of distress. Because everyone is different, there are no guarantees about what you will experience. It is important to be aware that you may also experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness as you are working through your problems. However, most people experience an improvement in their overall satisfaction with life. Initial _____

Confidentiality: Information you share with me will be kept strictly confidential and will not be disclosed without written consent. By law, however, your confidentiality is not guaranteed in life-threatening situations involving yourself or others, or in situations in which children, the disabled or the elderly are put at risk. All insurance companies require information that includes your diagnosis and dates and types of service performed. Sometimes they request additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). It is my policy to let you know of these requests immediately. Only with your written agreement will I comply with insurance companies' requests for this additional information. Please be aware that your decision may have an impact upon insurance companies reimbursement for my services. If I need to discuss your treatment with a colleague or supervisor, I will make a special effort to disguise identifying information. Initial _____

Fee Policies: We have agreed on a fee of $ _____ for each therapy session. Payments for sessions should be made at the beginning of each session. Knowledge of your insurance coverage is your responsibility. I do participate in some managed care insurance programs. If you will be using your insurance to pay for therapy you are responsible to know the details of your plan (copay, deductible, the need for authorization etc) and will be required to pay your copay each session. If you are using out of network benefits, I will provide the necessary documentation for you to submit for reimbursement from your insurance company. Please note that I use a billing service when billing insurance companies. Signing this grants me permission to share the necessary information with the billing company so that I get paid. Generally this involves your name, and the name of the person who holds the insurance if different from you, your DOB, address, insurance policy, dates of services, and a diagnosis. If you have any questions about the information I need to share, please ask me about it. You may notice on your statements that the insurance company pays a rate different from my stated rate. It is common practice for therapists to bill their rate, knowing that the insurance company has its

own rate system and will pay according to their guidelines regardless of the billed amount. This should not affect the rate you pay, as discussed above. Initial _____

Cancellations: In order to be successful, psychotherapy requires consistent attendance and commitment on the part of the client as well as the therapist. Once an appointment is scheduled, it becomes "your time," and unlike other professionals, it is unusual that I will be able to use that time to see other clients.

You will be expected to pay as much as $75-or half your usual fee-for appointments (not just your co-pay) that are forgotten or canceled with less than 48 hours notice. Please be aware that insurance companies will not pay for canceled or missed sessions. If you are sick or if the conditions make driving dangerous (ie: snow) you are encouraged to cancel and will not be charged as long as you have given at least 2 hours notice. Please have your phone nearby on snow days as I try to confirm/cancel appointments early in the morning. Initial _____

Phone, technology, emergencies: If you need to contact me by phone, you can leave a message on my voicemail at 207-706-6485. I am usually able to return calls within 24 hours, with the exception of weekends and holidays. If you are unable to reach me and feel that you cannot wait for a return call, please call the state Crisis Hotline at 888-568-1112 or 911 or go to your nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague you may contact in my absence. Initial _____

I use texting and email for scheduling purposes *only*. While my computer and phone are both password protected I cannot guarantee your confidentiality via text and email. Text and email are not appropriate ways to communicate serious concerns or therapy content.

When one or both of us are unable to get to my physical office, I use a HIPPA compliant online platform such as Zoom to conduct video sessions. When video is not an option, phone sessions may also be considered. It is your responsibility to determine if your insurance will pay for tele-therapy comparable to in person sessions. Please see addendum for tele-health consent. Initial _____

Physician Contact: Physical and psychological symptoms often interact. I encourage you to seek medical consultation if needed. If you are seeing me for issues related to a medical condition, I will be happy to collaborate with your physician and will ask you to sign a release of information form giving me permission to do so. In addition, medication may sometimes be helpful for psychiatric conditions. When appropriate I will refer you for a medication evaluation with a qualified doctor or advanced practice nurse. For the best patient care, please inform me of any medication that you are taking at the present time. Also, please inform me of any changes in your medication or medical condition when they occur. Initial _____

Problems/Freedom to Withdraw: If for any reason, something about our work together is bothering you, please discuss it with me. Problems that arise can often be the result of the very issues we are working on and should be discussed in therapy. You do have the right to end therapy with me at any time and if you wish, I can refer you to another qualified psychotherapist. Initial _____

Telehealth Addendum to Consent for Treatment

I understand that under certain circumstances (bad weather, health restrictions, pandemics etc) my provider may ask me to engage in a telehealth session using Zoom (or comparable), HIPPA compliant online conferencing platforms. Initial _____

My provider has explained to me how the video conferencing technology will be used to affect such a consultation and how such a session will be similar and different from a session when we are in the same room.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth session if it is felt that the video conferencing connections are not adequate for the situation. I agree to have my phone on hand should our video conference be disconnected so that we can discuss the disruption/termination. Initial _____

I understand that to protect my confidentiality, my provider will make every effort to be in a closed room so as to ensure no one else is present in the room when she is participating in a telehealth session, and that I am responsible to do the same on my end. If others are present during the consultation other than my provider and myself we will inform one another of their presence and that they will maintain confidentiality of the information obtained. Initial _____

I have had the alternatives to telehealth explained to me-including the option to decline sessions-and am choosing to participate in video teletherapy sessions _____

I understand that while in the state of Maine there is parity for teletherapy sessions, some insurances may still not pay for an online session if the patient is not located in a physician's office. Therefore I am agreeing to pay for my teletherapy session at the approved insurance rate (not just my co-pay/co-insurance), if my insurance company declines to pay for teletherapy. Initial _____

I understand that I must be located in a state where my practitioner holds a license to practice (currently Maine, Vermont and New Jersey)

In an emergency, I understand that the responsibility of my teletherapy provider is to advise my local practitioner if I'm in a physician's office, a family member and/or the local authorities if I am at home, and that the provider's responsibility will conclude upon the termination of the telehealth session. Initial _____

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. _____

Informed Consent: I have read and understand the preceding statements. I have had the opportunity to ask questions about these statement and I agree to enter into a professional psychotherapy relationship with Barbara Davis, LCSW

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).

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

_____

Patient Signature (if over 14) Date

_____

Provider Signature Date