

Client Information and Office Policy Statement Informed Consent

I. New Client: Welcome!

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist, Lyriss Bacchus Steuber, LMFT, will answer any questions you have regarding any of these policies.

II. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through psychological and spiritual healing and growth.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s).

You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

I. Appointments:

Appointments are usually scheduled for 50 minutes. The practice's hours are (Wed-Fri 9:00 – 6:00pm, Tues & Thurs 4:30 – 6:30pm). Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency, your therapist may be reached by at 407-417-7770. If you are unable to reach your therapist, you may call your primary care physician or the local emergency room, or a crisis hotline: (407) 425-2624.

II. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1.) Suspected abuse or neglect of a child, elderly person or a disabled person, 2.) When your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3.) If you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4.) If your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc. 5.) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6.) In natural disasters whereby protected records may become exposed or 7.) When otherwise required by law. You may be asked to sign a Release of Information so that you therapist may speak with other mental health professionals or to family members.

Lyriss Bacchus, LMFT – MT 2075

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Client Information and Office Policy Statement – continued

Ph: 407-417-7770

Fax: 407-862-4820

III. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are locked and kept on site.

IV. Fees:

Fee or co-pay for each visit is \$_____.

V. Payments:

Payment is due at the time of the session unless other arrangements have been made. Your therapist will file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit and to obtain prior authorization if necessary. At any time during treatment should I become ineligible for insurance coverage, I will notify the practitioner and understand I will become responsible for 100% of the bill.

VI. Cancellations and Missed Appointments:

You will be billed for a sessions that you cancel with less than 24 hours notice. You may leave messages 24 hours per day. You will be billed \$_____. Insurance companies generally do not reimburse for failed appointments.

VII. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your therapist, or any office policy please inform the Privacy Officer immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose.

VIII. Consent for Treatment

By signing below, you are stating that you have read and understood this 2-page policy statement and you have had your questions answered to your satisfaction.

If the patient is a minor, I certify that I am the legal guardian, having authority to consent to treat and release information. I agree to notify my therapist of any change in my status as legal guardian.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that participation in therapy is voluntary and I may withdraw from treatment at any time. I have requested a copy if I wish of this and any other form I have signed. I consent to have necessary information released in order to file an insurance claim.

Name of patient (please print)_____

Signature:_____

Date:_____

Therapist/Witness:_____