Courage Counseling

Lindsy Rilinger, LSCSW

729 ½ Massachusetts St. #214

Lawrence, KS 66044

P: 785-633-2743 - F: 785-640-8400

lindsy@couragecounselingks.com

Psychotherapy Informed Consent

Please carefully read and **initial each section** of the consent form. Please sign and date the end of the document to establish your agreement to the therapeutic treatment.

Practice

I am licensed by the Kansas Behavioral Sciences Regulatory Board as a Licensed Specialized Clinical Social Worker. I am a private practice psychotherapist and am associated with no other group practices. I have extensive experience with eating disorders and a history of treating trauma. I continually attend continuing education events to stay informed on evidence based practices and provide my clients with treatment informed by best practice guidelines. I am a certified Eye Movement Desensitization and Reprocessing (EMDR) therapist. My license does not permit me to practice medicine, perform surgery, or prescribe drugs.

I will complete an assessment within the first few sessions. During this beginning phase of treatment, the presenting struggles, goals of treatment, treatment plan and evaluation of my skill set meeting your needs will be addressed. I want to provide beneficial treatment to all of my clients which requires a mutual experience of positive rapport. If this therapeutic relationship does not fit for either party, at any point in the treatment process, I will make every effort to make an appropriate referral to best benefit you.

Sessions will be 50 minutes long. Allowing the final 10 minutes for scheduling and documentation.

_____

Confidentiality

Discussions between yourself and I are confidential. In order to adhere to best practice within your treatment I am a part of a consulting group. This is a group of fellow licensed mental health professionals. During consultation aspects of your treatment may be presented. This information will not include any identifying information. The least amount of information necessary will be shared during these consultations.

Information will be shared with other individuals or companies, as needed for payment of your bill. This includes your insurance company if they are the responsible party for payment. The law and requirements of my licensure allow myself to share other information with other individuals or entities in certain circumstances. Unless you authorize to do otherwise, your treatment information will only be shared outside my practice what the law allows.

The following are some, not all, situations where I am permitted or required to disclose information without either your consent or Authorization:

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- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the Psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the appropriate regulatory agency or the patient's employer
- If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observe a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, the law requires that I file a report with the appropriate regulatory agency. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to suspect that an elderly or disabled adult presents a likelihood of suffering serious physical harm and is in need of protective services, the law requires that I file a report with the appropriate regulatory agency. Once such a report is filed, I may be required to provide additional information.
- If I believe that it is necessary to disclose information to protect against a clear and substantial risk of imminent serious harm being inflicted by the patient on him/herself or another person, I may be required to take protective action. These actions may include, and/or initiating hospitalization and/or contacting the potential victim, and/or the police and/or the patient's family.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action.

By initialing below you are stating that you understand the confidentiality within the therapeutic relationship and the limits of such.

_____

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Physical Causes of Psychological Conditions

Many psychological and emotional conditions can be caused by an underlying medical illness. If you have not had a recent physical examination, it is recommended that you have one as soon as possible. Without a physical examination, possible medical causes for your symptoms cannot be ruled out. There is a connection between physical and mental health which may require collaboration with your medical doctor.

If you are seeking services for eating disorder support collaboration with your physician is likely to occur. Therefore, consent is necessary for us to engage in a therapeutic treatment process.

Physician's name: _____

Phone:_____ fax: _____

By providing your initials below you are indicating you understand the connection between physical and mental health and giving your authorization for consultation with your doctor when pertinent to your treatment.

_____

Terms of Treatment

Throughout the therapy process you may experience emotional strains and stresses as a result of the therapeutic process. Changes create new challenges that are often the key to positive growth. This growth occurs as individuals modify emotions, attitudes and behaviors that begin to impact significant areas of their lives. The therapeutic interventions I implement and recommend for you is based on best practice and accredited trainings to achieve the desired outcomes of your treatment plan. I cannot make any guarantee that therapy will improve your mental health, change your thought processes, or modify your behaviors. The therapeutic relationship is a cooperative one. While I am here to assist you in gaining insight, modifying behaviors, processing experiences and improving self-regulation skills to achieve your identified mental health goals the work is done by you. This is a therapeutic relationship which requires input and effort from both sides.

If a client demonstrates the inability to engage in services appropriately or follow treatment recommendations, I have the right to terminate service. Re-engagement will be addressed and considered on a case-to-case basis.

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Contact Outside of Scheduled Sessions and Emergencies

I provide my contact information to established clients. Contact outside of session may occur via voice call, e-mail, fax or text messaging. While I have taken precautions and have securities in place to protect your information there are always risks with electronic communication. By initialing below, you are authorizing communication via the designated form of communication and understand the limitations to confidentiality this holds and the associated risks.

voice call_____ e-mail_____ fax_____ text_____
I will not have contact with clients via any form of social media.
I cannot guarantee a response to crisis inquiries outside of session. If you are experiencing a crisis which requires immediate assistance it is your responsibility to contact additional support through natural resources, law enforcement or other entities outlined in your crisis plan. By initialing below you understand that electronic communication is limited and is not guaranteed a response.

_____

Fees for Services & Cancellations

I charged $200 for both the initial assessment and following 60 minute sessions. Follow up 45 minute sessions are $150. I do work with Blue Cross and Blue Shield and United HealthCare insurance and will bill expenses through your insurance if desired. It is your responsibility to contact your insurance provider to inquire about your mental health benefits. If you do not have mental health coverage you are responsible for full payment of services. All private pay amounts and co-pays are due at the time of each appointment. If additional charges accrue beyond this, I will mail you a statement. You will have 30 days from the statement to pay the additional charges. If payment has not been received within 30 days the card provided and stored on file will be charged the billed amount.

A 24-hour cancellation notice is required to avoid charges. If notice is not given prior to 24 hours from your scheduled session a charge will occur. The fee schedule is as follows:
1st incident of less than 24 hour cancelation notice: free
2nd incident: $25 of session fee
3rd incident and beyond: $50 of session fee
You will be held responsible for payment of this charge. Your credit card provided to be held on file will automatically be charged this fee. Your initials below indicate that you agree to the stated payments and understand you will be held responsible for what is not covered by insurance.

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Client Endorsement and Consent for Service

I ask that clients or their legal representative sign the following general consent to treatment. You may, at any time, decline specific recommendations.

· I understand that I may request referral to another provider at any time.
· I agree to give complete and accurate information as it becomes relevant. I waive any liability or responsibility on the part of the clinician when incomplete or inaccurate information has been given.
· I agree to discuss the termination with my clinician when I am ready to discontinue counseling.
· I have read and understand all of the disclosures listed above and had my questions answered.

By signing below, I give my full consent to Lindsy Rilinger, LSCSW, to provide myself or my child with psychotherapy services.

_____ _____
Signature of Client/Legal Guardian Date

_____
Printed Name of Client