



## **Informed Consent for Counseling and Psychotherapy for Minors**

### **Mental Health Services**

Ethos Clinics recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move towards resolving your difficulties. The therapist will strive to *assist* you grow towards greater health and wholeness by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our therapist works within the context of each individual's beliefs, and no attempt is made to impose personal theology.

### **Therapist**

The therapist is a trained professional engaged in providing mental health care services to clients directly as an employee of Ethos Clinics. The therapist has discussed with me the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. You may withdraw from treatment at any time, but please discuss this with your therapist.

### **Appointments and Cancellations**

Appointments are made by calling the office location most convenient for you (Lehigh: 610-900-4234, Bethlehem: 610-625-1486, Emmaus: 484-232-5288), Monday through Friday, between the hours of 9:00am and 5:00pm. If you are unable to get through when you call please leave a message with your name, purpose of your call, and a call back number and a staff member will get back to you within 72 hours. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment and the absence will be marked on your record. Third-party payments will not usually cover reimburse for missed appointments. Medicaid clients are not charged a fee per the law, but will be held accountable to the office No Show and Cancellation Policy (See the No Show and Cancellation Policy form). Your therapist reserves the right to cancel your appointment if you show up sick, late, or with minor children that might interfere with the counseling session.

### **Number and Length of Sessions**

The number of sessions needed depends on many factors and will be discussed by the therapist. The length of therapy sessions range depending on several factors and the therapist will discuss this with you as well.

### **Relationship**

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you. Gifts, bartering and trading services are not appropriate and should be shared between you and the therapist.

### **Goals, Purposes, and Techniques of Therapy**

There may be multiple interventions to effectively treat the problems that you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the



therapist and to have input in setting goals of your therapy. As therapy progresses, these goals may change.

### **Confidentiality**

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority.

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing the Receipt form for the Informed Consent and Privacy Practices, you are giving consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right to confidentiality that may result.

### **Duty to Warn**

In the event that the therapist reasonably believes that the client is in danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.

By signing Informed Consent and Privacy Practices form, you acknowledged that you have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices section of this form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by authorizing recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

### **Risks of Therapy**

Therapy is the Greek word for *change*. Clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

### **Payment for Services**



If you have insurance, different copayments are required by various group coverage plans. Your copayment is based on Mental Health Policy selected by your employer or purchased by you. You are responsible for and shall pay your copay portion of therapist's charges for services at the time services are provided. You are responsible for notifying Ethos Clinic immediately of any changes to your insurance. If you fail to notify Ethos Clinic of any changes to insurance, you may be billed for services that are not covered. **Ethos will look to you for full payment of your account, and you will be responsible for payment of all charges.**

### **Court**

Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by the law. In the event disclosure of your records or therapist's testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate for giving that testimony. Such payments are to be made prior to the time the services are rendered by the therapist. The therapist may require deposit for anticipated court appearances and preparation.

### **After-Hour Emergencies**

Emergencies are defined as urgent issues requiring immediate action. **If you are experiencing a psychiatric or medical emergency and reach the business after hours, call or report to your local emergency room immediately.** Other national resources include, but are not limited to: Suicide Prevention Hotline, 1-800-273-8255 ;MH Warm Line, (866) 854-8114 ;Suicide Prevention Text Services: text 741741; <https://suicidepreventionlifeline.org/> ; <http://www.yourlifeyourvoice.org>

### **Therapist's Incapacity or Death**

In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing Informed Consent and Privacy Practices Receipt, you give consent to another licensed mental health professional at Ethos Clinic to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

### **Consent to Treatment**

By signing Informed Consent and Privacy Practices Receipt, you voluntarily agree to receive mental health assessment, care, treatment or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment or services at any time. By signing the informed Consent and Privacy Practices Receipt, you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

### **Contact Information**

By signing the Informed Consent and Privacy Practices Receipt, You are consenting for Ethos Clinic to communicate with you by mail, e-mail, and phone at the address and numbers provided at the initial appointment, and you will immediately advise Ethos Clinic in the event of any change. You agree to notify the Center if you need to opt out of any form of communication.



**General Consent for Care and Medical Treatment**

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Client Name Print \_\_\_\_\_ DOB: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Name Print: \_\_\_\_\_ Relation: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Name Print: \_\_\_\_\_ Relation: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_