Compassionate Hearts Therapy, LLC

Informed Consent for Psychotherapy

Welcome to Compassionate Hearts Therapy, LLC! I am excited to get to know you and look forward to collaborating with you to meet your goals. The first step in a new direction is often the hardest to take, and I am honored to accompany you on this journey. This document is intended to provide important information to you regarding our professional services and business policies. Please read the entire document carefully and be sure to ask any questions that you may have regarding its contents before signing it.

The Process of Psychotherapy, Risks, and Benefits:

While it may not be easy to seek help from a mental health professional, psychotherapy has been shown to be beneficial for individuals who fully engage in the process. The process of psychotherapy involves a commitment of time and energy. Your therapist, in using the internal family systems model of therapy, will assist you in building greater personal self-awareness and insight into your own experience of internal conflicts, exploring what you experience as unresolved, and gaining resiliency through self-agency. It will be important for you to be an active participant in the therapy, to work to explore your own feelings and thoughts and to try new approaches in order to facilitate change; however, there are no guarantees that can predict what individual experiences may occur. Therapy is the Greek word for change. You may learn things about yourself that you do not like. Often growth cannot occur until you experience and confront issues that induce you to feel sadness, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts, and the realization that you are responsible for lifestyle choices/changes that may result from therapy. There may be times in which I will gently challenge your perceptions and assumptions and offer different perspectives to support your pathway towards healing. Sometimes in the process, clients may feel worse prior to feeling better. This is because personal change is a big decision and life adjustment, and a sustainable change with results requires the type of courage, motivation, and commitment that got you here today! If you notice any feelings of discomfort during the process, I encourage you to please bring those to my attention for deeper processing.

Information About Your Therapist:

Shelly Johnson, LMHC CIFST received a Master of Arts Degree in Counseling Psychology from St. Xavier University in Chicago, Illinois and is a Licensed Mental Health Counselor in the state of Iowa. Shelly was professionally awarded her CIFST (Certified IFS Therapist) from the IFS Institute in 2021. Prior to this, she received specialized Level 1, Level 2, and Level 3 training, along with other advanced training in utilizing the Internal Family Systems (IFS) model of psychotherapy. She has previously volunteered for an extensive time in Chicago as a Program Assistant or PA for assisting Level 1 IFS trainees. Although heavily influenced by Internal Family Systems (IFS), she practices from a strengths-based, trauma-sensitive, psycho-dynamic professional orientation, utilizing an eclectic array of techniques from multiple psychotherapeutic theories in order to meet the unique needs of her clients.

The Therapeutic Relationship:

Your relationship with this 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 business relationships undermine the effectiveness of the therapeutic relationship. This therapist cares about helping you but is not in a position to be your friend or to have a social or personal relationship with you. If this therapist encounters you in a public setting, in order not to reveal your identity the therapist will not acknowledge your presence unless addressed by you first. Gifts, bartering and trading services are not appropriate and should not be shared between you and this therapist. These boundaries are important for ethical, effective psychotherapy.

Financial and Payment Policies:

This therapist is considered an in-network and out-of-network provider. While you may intend to use health insurance to cover some or all of your fees, please note that you are ultimately responsible for fees for services incurred. I recommend that you contact your insurance company before we meet to find out what exactly is covered. All payments are due to the clinician at the time of service. Checks, cash and credit/debit cards are accepted for payment of services. If you choose to pay with cash, please have the proper amount, as I do not provide change. If a check is returned due to insufficient funds, a reprocessing fee of $35 will be charged. Subsequently, all payments will be requested in cash or credit card. Minor children must come with form of payment. Private pay and insurance are common payment options. I will file your primary insurance, as a courtesy, but each client is responsible for contacting his/her insurance company **prior** to the first session in order to understand their mental health benefits, including the financial responsibility concerning deductibles, co-insurance, and co- payments. My office does not assume any responsibility for denial of any or all parts of client claims by any insurance company. If you choose to forgo insurance and pay privately the fees are as follows.

Initial Appointment	$175.00
30 Minute Psychotherapy Session	$80.00
45 Minute Psychotherapy Session	$125.00
60 Minute Psychotherapy Session	$160.00
Late (less than 24 hours) cancel or no-show (not covered by insurance)	$50.00

Confidentiality and When Disclosure is Required:

I will make every effort to keep your protected health information (PHI) private. Information shared within the context of the therapeutic relationship will be held in confidence and will not be released without your signed written consent. There are certain circumstances or situations in which I am required by law to disclose your PHI without additional consent, including the following: if there is a reasonable suspicion or I am made aware of child, dependent, or elder abuse or neglect; if a client poses a clear risk of danger to self, to others, to property, or is gravely disabled; if a client's family members communicate to the clinician that the client is a danger to his or herself or others; or if I am subpoenaed by a court order from a Judge; during professional consultation. I will use my best clinical judgment, to determine if it is necessary to warn, protect, notify, or disclose your PHI. **For further information, review the Notice of Privacy Practices furnished to you by your therapist in conjunction with this Informed Consent for Psychotherapy document. By signing this consent form below, you acknowledge receipt of a copy of the Notice of Privacy Practices**.

If you have any questions regarding confidentiality, you should bring them to the attention of this therapist so that the matter can be discussed further. By signing this informed consent form below, you are giving your consent to the undersigned therapist to share confidential information with all persons mandated or permitted by law, and you are also releasing and holding harmless the undersigned therapist for any departure from your right of confidentiality that may result.

Duty To Warn

In the event that the undersigned therapist reasonably believes that you are in danger, physically or emotionally, to yourself or another person, by signing this Informed Consent for Psychotherapy form below, you specifically consent for the therapist to warn the person in danger and to contact any person in position to prevent harm to yourself or another person, in addition to medical and law enforcement personnel, and the following persons:

Name Telephone Number

_____

Support person: *Support* person:

_____

This information is to be provided at your request for use by said persons only to prevent harm to yourself or another person. This authorization shall expire upon the termination of your therapy with the undersigned therapist. You acknowledge that you have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. 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 copy of the Notice of Privacy Practices of the undersigned therapist that you have received and reviewed. You further acknowledge that the treatment provided to you by the undersigned therapist was conditioned on you providing this authorization.

Contact Information:

You consent for the undersigned therapist to communicate with you by mail, email and by phone at the following addresses and phone numbers and you agree to IMMEDIATELY advise the therapist in the event of any change:

Mailing Address:

_____

Telephone Number(s): E-Mail Address:

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Confidentiality Professional Records:

Compassionate Hearts Therapy, LLC does keep Protected Health Information (PHI) about you in the records. This information includes your reason for coming to therapy, diagnosis, goals set for treatment, progress towards goals, medical and social history, prior treatment history, any past treatment records received from other providers, billing records, and any reports that have been sent to anyone, including future reports to your insurance carrier. Clients may request in writing to view his/her clinical record at any time and you will have access except for in circumstances that involve danger to yourself and/or others or make reference to another person (unless such other person is a health care provider) and we believe access is likely to cause substantial harm to such other person. Please note that by geographic law, Compassionate Hearts Therapy is the owner of the record including all transcripts, notes, and emails.

Patient Rights:

According to HIPAA, regarding your Clinical Records and disclosures of protected health information, your rights include requesting that I amend your record. This means you can request to restrict what information from your Clinical Record is disclosed to others, request an accounting of most disclosures of protected health information that you have neither consented to nor authorized, determine the location to which protected information disclosures are sent, have any complaints you make about my policies and procedures recorded in your records, and the right to a paper copy of this Agreement, the attached Notice of Privacy Practices form, and our privacy policies and procedures.

Collaboration and Consultation with Other Professionals:

I do not believe in working in isolation. In order to provide quality services, this Therapist may collaborate with other professionals in a client's life as appropriate, such as family members, a physician, psychiatrist, past therapists, and/or other mental health professionals. Clients will be asked to complete a release of information authorizing these exchanges. In some cases, services may not be provided without this. With the purpose of giving you the best clinical care, it is appropriate for me as your therapist to discuss your care (as needed) with other professional colleagues that I meet with regularly for ongoing consultation, supervision, and coordination of care; however, with any information I share, each client's identity remains completely anonymous and confidentiality is fully maintained. If you have questions or concerns, please make sure to address these concerns with me.

Appointment Scheduling and Cancellation Policy:

Consistent attendance to therapy sessions greatly contributes to a successful outcome. It is common for clients to be seen on a weekly or bi-weekly basis. However, frequency and duration of treatment is 'dependent' on your presenting issues and goals for treatment. When you schedule an appointment, understand that I reserve that time specifically for you. Should the need to cancel or reschedule arise, please give me at least 24 hours notice (via work voicemail at 515-635-5763 or email at (shelly@chtherapy.care) so that I may offer that time to someone else. The fee for late cancellations or no shows is $50 and will be due at the time of the next scheduled session. Exceptions to this policy may be granted at the discretion of this therapist in the event of an unexpected illness or emergency. Scheduling of appointments, cancel or change of appointments, may be done using the email provided or by contacting 515- 635-5763. If you are late for an appointment, the session must still end at the scheduled time, as there will usually be someone else waiting for the next appointment time. For scheduled sessions, if you have not arrived within fifteen minutes of the scheduled appointment and there has been no ability to connect with an outreach attempt, the session will be treated as a cancellation without 24 hours notice.

Appointment Reminders:

Clients often request reminders for their appointments to avoid missing or having to pay for a missed appointment. To assist with this need, Compassionate Hearts Therapy will provide a reminder voicemail and/or email the day before your appointment. Should you desire appointment reminders, please indicate your preferred appointment reminder method further ahead on this form. The information you provide will be used for scheduling purposes only, and will not contain clinical information.

Contacting Me and Emergencies:

Due to the hours of my work schedule, I am often not immediately available by telephone or email.

Please note that I do not answer the phone when I am in session. I will make every reasonable effort to return calls the same day I receive them during normal business hours, but

there may be times where I am not always able to do so; in this case, please allow 24-48 hours for a returned call with the exception of weekends or holidays. You may call and leave messages for me Monday – Friday between the office hours of 9am - 6pm at (515) 635-5763. I retrieve voice messages Monday through Friday, which I typically monitor from time to time throughout the day. Messages left after hours or on weekends or holidays will normally be returned the next business day. If you are difficult to reach, please inform your therapist of times when you will be available.

If you have an emergency, please call 911 or go to your local emergency room. Compassionate Hearts Therapy is a practice limited to clients who typically do not require 24-hour-care or crisis/emergency care. Please know that this therapist **does not** provide twenty-four (24) hour crisis or emergency therapy services. Therefore, I am not reachable 24 hours per day. If you feel you have a need for this level of care, please inform your therapist so that I may refer you to an appropriate therapist or facility. If, during our work together, an emergency does occur which requires immediate mental health attention, please support the Therapist's clinical judgment to immediately call 911 or if you are able to safely transport yourself, direct you to go to your nearest hospital emergency room for assistance. If you have an urgent matter and need to speak to someone immediately, please call the Des Moines Broadlawns Medical Center 24-hour Crisis Team for assistance at 1 (515) 282-5752. When I am out of town, I will either make arrangements for another licensed Therapist to be available during my absence, or direct you to the Broadlawns Crisis Team for assistance.

Electronic Communication Policies:

Email and Phone calls/Voice Messages: There are risks to confidentiality with any electronic modality. Please be aware that these methods of communication cannot be guaranteed to be confidential, but that this Therapist will use reasonable means to maintain security and confidentiality of email or phone calls sent and received. If you choose to email me from your personal email account, it is best to limit the content to housekeeping issues such as scheduling and changes in contact information. When choosing either of the above methods of communication, please be aware of any friends, family or co-workers who may have access to your phone or computer. Also, you agree and understand that for this reason, electronic communications is for business-related or logistical communications, such as scheduling and confirming appointment details and times, and NOT as a means of therapy. **Any therapy related questions or issues will not be addressed by the therapist in any electronic communication but will be dealt with during your next therapy session.**

Conditions for the use of email: The Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email will be read and responded to within any particular period of time.

b. Email should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations and should not use email for communication of sensitive medical information.

c. Provider is not liable for breaches of confidentiality caused by the client or any third party.

d. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers.

Social Media:

Your therapist does not accept friend or contact requests from current or former clients on any social networking sites. While a healthy therapeutic relationship is at times very personal in nature, it is important to be clear that the relationship between a client and therapist is a professional one; therefore, I will not communicate with, accept personal friend/ connection/follow requests, or contact you through social mediums like LinkedIn, Twitter, Instagram, or Facebook. In addition, if an accidental association has occurred and is discovered, I will cancel that online relationship immediately. This act is necessary because these types of casual social contacts can create significant security risks for you. Adding clients as friends or contacts on these sites can compromise confidentiality and privacy of both the therapist and the client. It can blur the boundaries of the professional relationship and are not permitted.

Therapist's incapacity or Death:

You acknowledge that, in the event that the undersigned therapist becomes incapacitated or passes away, it will become necessary for another therapist to take possession of your file and records. By signing this Informed Consent for Psychotherapy form below, you give consent to allowing another licensed mental health professional selected by the undersigned therapist, to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice. The undersigned therapist will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

Audio and Video Recordings:

You acknowledge and, by signing this Informed Consent for Psychotherapy form below, agree that neither you or the undersigned therapist will record any part of your sessions **unless you and the therapist mutually agree in writing** that the session may be recorded. You further acknowledge that the undersigned therapist objects to you recording any portion of your sessions without the therapist's written consent.

Client/Responsible Party Acknowledgment and Acceptance of Terms

I, voluntarily, agree to receive mental health assessment or intake, care, treatment, or services, and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I have the right to stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing this Informed Consent for Psychotherapy Form, I, the undersigned client (parent or guardian), acknowledge that I have read, understood, and agree to be bound by all the terms, conditions, and information it contains. I acknowledge also that I have been offered a copy of each of the following forms: Informed Consent for Psychotherapy, Addendum to the Informed Consent for Psychotherapy, Notice of Privacy Practices, and Business Policies. I acknowledge that ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me prior to signing this consent and participating in services.

By signing this document, you are affirming that you have read and understood my Informed Consent for Psychotherapy and that a copy was either offered or provided to you.

Client(s)

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Print Name(s) Here **Sign Here** **Date**

As witnessed or confirmed by:

_____

Shelly Johnson, LMHC CIFST, Therapist **Date**

Addendum to Informed Consent for Psychotherapy

Scope of My Practice and Services: Shelly's specializations are based on her expertise & training & her practice is focused on treating individuals who have the following struggles or symptoms: depression, anxiety & fear, performance anxiety, grief & loss, panic attacks, personal growth, communication, life transitions, academic issues, learning difficulties, addiction, OCD, ODD, anger management, chronic pain, work/life balance & self care, motivation, compassion fatigue, betrayal & trust issues, behavioral & interpersonal issues, boundary setting, coping strategies, codependency, spirituality & faith, sexuality, existential challenges & exploration, peer relationships, bullying, self esteem, PTSD, self-harming behaviors, stress management, workplace issues, suicidal thoughts, weight management, relational & family issues, marital issues, divorce & parenting, eating disorders, body-image concerns, mind-body connection, empowerment coaching, women's issues, adoption, attachment work, perfectionism, caregiver stress & shame.

PLEASE NOTE: While I am qualified to work with a wide variety of clients (children, adolescents, and adults) with a wide array of presenting symptoms or issues, I may not feel that my training and expertise is adequate enough to effectively treat certain conditions or disorders including personality disorders or severe trauma. While I am qualified to assess and treat individuals with abuse, in cases with minor children, I do not 'specialize' in "discovery work"; there are professionals I can provide you with names of that are highly trained in and specialize in working with children's rights and care and abuse. I reserve the right to refer clients (regardless of diagnoses) to another qualified professional if it is clinically and ethically necessary to do so and in the best interests of the client. We may find in the beginning or during the process of therapy that I am not the best professional fit for you. If this is the case, I reserve the right to discuss appropriate referrals with you to 3 other skilled professionals who are better qualified to serve you. I will do my best to make sure that that transition is smooth. If you feel that you are in need of more support than I can offer you through weekly psychotherapy, than I reserve the right to refer you to a different, more restrictive or intensive treatment, if I believe you exceed the level of care I can offer. I also reserve the right to discontinue services at any time and you reserve the same right as well.

Statement of Validation: ***I have read this Addendum to Informed Consent for Psychotherapy, it has been adequately explained to me, and I understand its contents.***

Client(s)

_____

Print Name Here **Sign Here** **Date**

_____

Print Name Here **Sign Here** **Date**