

## 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 your treatment. 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:**

Psychotherapy is an intentional and goal-directed relationship with a professional therapist, and has been shown to be beneficial for individuals who fully engage and actively participate in the process. Psychotherapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems, and gaining resiliency through self-agency; however, there are no guarantees that can predict what individual experiences may occur. The process of psychotherapy involves a commitment of time and energy and often involves talking about unpleasant aspects of your life; you may, to some degree, experience uncomfortable triggers or negative feelings. You may experience discomfort from remembering and discussing unpleasant memories, The process may evoke strong feelings of sadness, anger, fear, anxiety, etc. 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, so that a potential growth opportunity may be available to you that will maximize your learning.

### **Information About Your Therapist:**

Shelly Johnson, MA, LMHC received a Master of Arts Degree in Counseling from St. Xavier University in Chicago, Illinois and is a Licensed Mental Health Counselor in the state of Iowa. She has received specialized Level 1, Level 2, and Level 3 training, along with advanced trainings in utilizing the Internal Family Systems (IFS) model of psychotherapy. She is currently volunteering in Chicago as a Program Assistant or PA for weekend 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 out-of-network provider. I am only accepting private pay (at this time) and anticipate accepting more insurance coverages in the very near future. My fee is based on a 50 minute clinical hour. The initial intake session fee is \$125 and a regular clinical session fee is \$85. An adjusted or reduced fee is available by request for persons affected by unemployment or other hardship circumstances and will be based on a sliding fee scale. This rate is set by your therapist at the first session. Payments are due in full 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. Minor children must come with form of payment. 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.

## **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, except for professional consultation if needed and unless required by law.

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.

## **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 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 shellytjohnson@gmail.com) so that I may offer that time to someone else. The fee for late cancellations or no shows is \$30 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 on the Client Registration 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 nor email. Please note that I do not answer the phone or check my email when I am in session. I will make every attempt to return calls and emails the same day I receive them but I am not always able to do so; in this case, please allow 24-48 hours for a returned call or email response 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 and email messages Monday through Friday. Messages left after 6pm Friday will be returned the following Monday. If you do not hear from me, assume my voicemail was not working properly and try calling again. 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. Therefore, we are not reachable 24 hours per day. If you feel you have a need for this level of care, please inform your therapist so that we may refer you to an appropriate therapist or facility. If, during our work together, an emergency does occur which requires immediate attention, please support the Therapist's clinical judgment to call 911 or direct you to go to your nearest hospital emergency room. 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.

**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.

**Social Media:** 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.

### **Client/Responsible Party Acknowledgment and Acceptance of Terms**

**I understand that this agreement is valid during the time that I am participating in services with Compassionate Hearts Therapy. I have read, understand, and agree with this document's content and have been offered a copy of the Informed Consent for Psychotherapy and Addendum to the Informed Consent for Psychotherapy. I acknowledge that I have had an opportunity to have my questions answered prior to signing this consent and participating in services. I am aware that I have a right to stop therapy at any time.**

**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**

**Client(s)**

**Print Name Here**

**Sign Here**

**Date**

**Print Name Here**

**Sign Here**

**Date**

## ADDENDUM to Informed Consent for Psychotherapy

### Scope of My Practice and Services:

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

**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. 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 do not provide custody evaluation or recommendations, nor medication or prescription recommendations nor any legal advice, as these activities do not fall within my scope of practice. 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 Statement of Services, 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**