Name _____
Date of Birth_____

Consent for Treatment

1. **New Client**

   You have taken a positive step by choosing to enter therapy. Life can, at times, be quite uncomfortable, difficult, and even painful. Therapy is an opportunity for you to create space for both healing and growth.

   This intake packet will acquaint you with information relevant to treatment, confidentiality, and office policies. Katie Dorsten, IMFT will answer any questions you may have regarding any of these policies.

2. **Goals**

   The goal of therapy is to improve your quality of life in whatever way that may be for you. In any case, I believe achieving our personal goals and becoming more of our true selves involves a bit of discomfort which leads to a lot of growth.

   You are responsible for your treatment. This means you're responsible for communicating the information necessary for me to facilitate effective treatment, identifying goals, and doing the work outside of sessions to increase positive outcomes.

3. **Appointments, Counselor Availability, and After Hours Emergencies**

   Appointments are usually scheduled for 45-55 minutes. Clients are generally seen weekly or as determined by you and I. Katie Dorsten, IMFT office hours are Monday and Tuesday 9am-6pm. I am not immediately available by telephone. Voicemail/text messages are checked during normal business hours. Messages left outside of normal hours of operation (Mon/Tues 9-7) will be answered within the next 48 hours, with the exception of holidays and weekends. In the event of an emergency, dial 911, call Crisis Care at (937) 224-4646 or go to the nearest emergency room. If you are feeling suicidal, do not contact me since I may not be available 24/7. Instead, it is your responsibility to seek out help immediately through your local emergency room or community crisis care.

   I will receive and respond to text messages, however, please be advised that text messages are unencrypted forms of communication and could result in an unintended breach of confidentiality. By signing this form you are agreeing to send and receive unencrypted text messages Please be advised that I may not check or respond to text messages for a period of 2 business days or longer.

4. **Social Media Policy**

   I do not accept friend or contact requests from current or former clients on any social networking site. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It

may also blur the boundaries of our therapeutic relationship. I have created a professional Facebook (Katie Dorsten, IMFT) and Instagram (@greenhousetherapist) page of which you are welcome to follow should you choose. I regularly post content that will be helpful to my clients and community on these pages. Be aware that following these pages may, in a way, compromise your confidentiality as others can see that you follow the pages. Do so at your own discretion.

5. **Confidentiality**

   Information and issues discussed in therapy are important and generally legally protected as both confidential and privileged. However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse/neglect of children, elderly, or disabled persons, 2) when a therapist believes you are in danger of hurting yourself or another person, or that you are unable to care for yourself, 3) if you report that you intend to physically injure another person, the law requires your therapist to inform that person, as well as, the legal authorities, 4) if your therapist is ordered by a judge to release information as part of a legal involvement in court proceedings, 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 your therapist may speak with other mental health professionals or to family members for continuity of care.

6. **Record Keeping**

   A clinical chart is maintained describing your diagnosis, treatment plan, progress in treatment, dates of services 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 behind two locks on site, and/or stored within the Electronic Medical Record (EMR). Request for medical records will be subject to medical records copying fees in accordance with Ohio Revised Code 3701.741.

7. **Fees and Appointments**

   Appointments are approximately 45-50 minutes in length and generally take place on a weekly basis unless otherwise decided upon by you and your therapist.

Name _____
Date of Birth_____

Fee Schedule

Initial Assessment……..$125
Individual Session……..$100
Couples Session……....$100
Family Session……...$100
Conjoint Couples Session…….$200

8. **Document Review, Writing, and Telephone Services**

   Document review and writing, as well as, telephone services provided via telephone/skype/facetime are not covered by your insurance. Telephone calls lasting more than 15 minutes and document review/writing services will be billed directly to you at a rate of $100 per hour. Services will be billed in 15 minute increments.

9. **Court Appearance or Testimony**

   Court appearance or testimony is billed at an hourly rate of $200 per hour, portal to portal, plus mileage and expenses. Court preparation time, as well as, time spent consulting with attorneys will also be billed. A copying and filing preparation charge will be billed for records or other materials subpoenaed. The individual requesting this activity will be billed separately from regular charges and payment is due in full upon receipt of the statement. A prepaid deposit may be required before this service is rendered.

10. **Payment**

    Payment is due at the time of session. Your therapist will file your insurance claim (if in network with your insurance), but you are responsible for deductibles, co-insurance, and co-payments, and OON (out of network) cost. **It is your responsibility to familiarize yourself with your insurance benefits.** I ask that you pay your deductible, co-pay, or out-of-pocket fee at the time of service by cash, check or Visa/MC/Discover. Should you choose to use OON benefits, I will provide you with a monthly superbill to provide your insurance carrier.

11. **Late Cancellations/No Shows and Missed Appointments**

    I request 24 hours' notice if you need to reschedule or cancel an appointment. The first time you no-show or late-cancel an appointment, you will not be charged. The second time, you will be billed for half the cost of a session without insurance (insurance companies do not reimburse for missed sessions). The third time, and beyond, should you no-show or late-cancel an appointment, you will be billed automatically with the credit card on file for the total out-of-pocket cost of the session.

Name _____
Date of Birth_____

12. Child Care Release

Katie Dorsten, IMFT does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up on time following their appointments. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child.

13. Complaints

You have the right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, or any office policy, please inform me immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier, or contact the Counselor, Social Worker and Marriage and Family Therapist Board of Ohio at (614) 466-0912.

14. Termination Agreement

Clients who have not been seen in over 60 days (or within a mutually agreed upon time) will be considered inactive. This means I will close your file and you will no longer be considered a client of mine. It is always preferable to have a final session before ending therapy in order to review and evaluate the sessions and assess overall progress. There are therapeutic benefits to saying goodbye and ending treatment with a discharge session. However, I will certainly respect your decision to end therapy if you choose not to return.

15. Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to expect that Katie Dorsten, IMFT will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you. Kaite Dorsten, IMFT reserves the right to discontinue therapy at any time including, but not limited to, a violation by you of this Consent to Treatment, a change or re-evaluation by Katie Dorsten, IMFT of your therapeutic needs, Katie Dorsten, IMFT's ability to address those needs, or other circumstances that lead Katie Dorsten, IMFT to conclude in its sole and absolute discretion that your counseling needs would be better served in another counseling facility. Under such circumstances, Katie Dorsten, IMFT will provide appropriate referrals.

Consent for Treatment

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

Name _____
Date of Birth_____

Print Name: _____ Date_____

Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient/source of your authority to sign this form.

Relationship to the Patient: _____ Print Name: _____

Name _____
Date of Birth_____

Registration

I am seeking: O Individual counseling O Couples Counseling O Family Counseling

Note: Only one set of paperwork is needed per course of therapy

Client Information

Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email: _____

On which number may I leave a message?: O Home O Cell

Are text messages okay?: O Yes O No

How did you hear about my counseling practice? _____

Insurance

Will you be using insurance to help pay for treatment?: O Yes O No

Insurance Carrier: _____

Address: _____

Phone #: _____

Are you the subscriber of this policy?: O Yes O No

If no, who is?: _____ Relation to you: _____

Subscriber Address (if different than yours): _____

Name _____
Date of Birth_____

City: _____ State: _____ Zip:_____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

I am: O Self Employed O Unemployed O Retired

I am: O Single O Married O Divorced

How many people live in your household? _____

Emergency Contact

Notify: _____

Relationship: _____

Phone: _____

Name _____
Date of Birth_____

History

Reason for starting therapy: _____
_____

Problem Areas: Circle all that apply

Family Work/School Anger Behavior Depression

Relationships Anxiety Addiction Eating Other _____

What do you hope to accomplish in therapy?: _____
_____
_____

Have you ever engaged in therapy in the past? O Yes O No

If yes, please state reason and outcomes: _____
_____

Has anyone in your family had a history of mental illness? _____
_____
_____

Are you currently taking any medications? O Yes O No

If yes, please list medication(s) and dosage: _____
_____
_____

Is there anything else you would like me to know before we begin your treatment?

_____
_____
_____

Name _____
Date of Birth_____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR THE TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Patient Name: _____

Patient Address: _____Patient Phone #: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health operations involving my office.

I have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your confidential information for purposes of payment may include the submission of your personal information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers of insurers for claims review, the determination of benefits and payment; or our submission of your personal information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at my office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for services, and to perform mental health treatment. You can revoke this consent in writing at any time unless I have already treated you, sought payment for services, or performed health care operations in reliance upon my ability to use or disclose your information in accordance with this consent. I can decline to serve you if you elect not to sign this consent form.

You have the right to ask me to restrict the uses or disclosures made for purposes of treatment, payment or mental health treatment, but as described in my Notice of Privacy Practices, I am not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. My Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY CONFIDENTIAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Patient Signature:_____Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:
Relationship to patient: _____ Print Name: _____