



INFORMED CONSENT FOR PSYCHOTHERAPY/PSYCHOLOGICAL SERVICES

Patient Name: _____ Therapist Name: _____

License Number: _____ Licensed: _____

Welcome to SCIHP’s Behavioral Health Department! You will be provided with information about your therapy and your therapist’s background. Please read this document as it explains our services, our limits of confidentiality, your rights, and grievance procedures.

Appointment and scheduling: Your appointment time is valuable and you are expected to show up at the scheduled time. You will be given the number to your therapist’s direct confidential line and if you need to leave a message, unable to keep the appointment or if you are going to be late, please call as soon as possible.

Your appointments for ongoing therapy will be scheduled by your therapist. Appointments are generally once per week or bi-weekly for 45 or 50 minutes or as agreed upon by you and your therapist. If you arrive late, you will have less time with your therapist. Excessive “no shows” will affect your ability to schedule future appointments.

The first appointment will be an assessment and treatment plan.

Fee: Qualified Native Americans are guaranteed medical services by federal law. However, services are not free. It is very important that this clinic be able to bill your insurance in order to be able to keep providing these services to the community. If you have insurance, please inform us and provide us with the required information in order for us to make a copy. If you are eligible for insurance benefits, sign up as soon as possible.

If you are non-Native and not living in a Native American household, you will be billed for services provided.

Confidentiality: State law and professional ethics require therapists to keep your detailed psychotherapy information private (confidential) except for the following situations:

- | | Initial |
|---|----------------|
| 1) If there is suspected child abuse, elder abuse or dependent adult abuse. | _____ |
| 2) Tarasoff, in which a patient makes a serious threat to do serious harm to a specific individual. | _____ |
| 3) When an intent to injury or kill oneself is communicated to the therapist. | _____ |
| 4) If you are required to sign a release of confidential information by your medical insurance. | _____ |
| 5) If you are involved with private or public agencies which request records, you must sign a release of information. | _____ |
| 6) If our records are subpoenaed by a court of law, we must provide a copy of your chart. | _____ |

If you participate in psychotherapy in compliance with a court order or an outside agency (CPS, Probation, etc.) mandate, you must sign a Release of Information form if we are to inform them of your attendance, case planning and progress.

SCIHP takes confidentiality very seriously. The details of your psychotherapy notes cannot be read by other SCIHP departments without prior consent. However, because health records are now electronic, your scheduled

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appointment times, current prescribed medication, labs and diagnosis may be seen for billing and professional services. If you have any questions or concerns about the confidentiality of your treatment, please discuss with your Provider.

Only upon your authorization, your medical provider may be able to access your Assessment and Plan section of your record, if requested, and deemed appropriate as it pertains to your clinical treatment.

I, _____, allow my medical provider to view the assessment and plan section of my behavioral health record upon my providers request if deemed appropriate as it pertains to my clinical treatment. I understand that allowing access to this information is optional. However, I understand that my refusal to sign my behavioral health provider may not be able to coordinate my care with my medical provider.

Patient/Legal Guardian Signature

Date

Name of Parent/Legal Guardian (please print)

Relationship to Patient

To protect your confidentiality, let us know if we can leave a message at the phone number you have given us and let us know if your number changes.

- Yes, you may leave a message for me. The best number to call is: _____
- No. Please do not leave a message for me on my phone.
- Alternate method of contact: _____

Emergencies: If you have a psychiatric emergency, please call 911 or go to the nearest emergency room. If you are in crisis during business hours, please call your therapist or the Behavioral Health Department at (707) 521-4550 for assistance. If you should have a crisis after hours, please call the Behavioral Health Department to be connected to the answering service and ask for the on-call Behavioral Health therapist.

About the therapy: Psychotherapy is not easily described in general terms. It varies depending on the type of therapy provided and the patient, and the particular problem(s) you bring forward. It is a professional relationship with special limits and boundaries which will make it more effective. There are many different methods that can be used to deal with the problems that you hope to address. Psychotherapy is not like a medical provider's visit. Instead, it calls for a very active effort on your part. Therapy is not always easy. Change may come more slowly than you would like. Therapy can benefit you in many ways, but may come with some risks. Therapy often involves discussing uncomfortable feelings or uncomfortable memories. Patients and therapists are partners in the therapeutic process. Therapy can lead to better relationships, solutions to specific problems, less anxiety and better mood and a general reduction in feelings of distress. We are unable to predict the length of your therapy or guarantee specific outcomes. The more you invest in the process, the better the possible outcome. You may have been referred by your medical provider and may not want, or be ready for therapy. If so, just let your provider or your therapist know.

Stopping therapy: You may stop therapy at any time. However, it is to your benefit that you let your current therapist know that it is time to stop and to make a plan about how to end the relationship which includes at least one to two sessions. Therapy can resume at any time. However, you may be assigned to a different therapist

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when you resume therapy. If you wish to continue in therapy and see someone else, let your current therapist know and a referral will be made.

Dissatisfaction/Grievance: You have the right to voice a complaint or dissatisfaction about your therapy at any time. We encourage you to speak with your therapist first. However, if you wish, you can contact the Behavioral Health Director about your dissatisfaction. There is also a grievance form which you may fill out and submit to the Patient Services Coordinator at any time during this process.

Acknowledgement:

By signing this form, you acknowledge that you have received a copy of this consent, and have read and understand the contents and agree to participate in therapy. It also acknowledges that you understand that you may ask questions at any time, if you need more information.

If you decline to sign this Informed Consent for Psychotherapy/Psychological Services, allowing your diagnosis, medication, labs and appointments to be entered into the Electronic Health Record, service for treatment should be sought elsewhere.

Patient Name (please print)

Patient/Legal Guardian Signature

Date

Name of Parent/Legal Guardian (please print)

Relationship to Patient

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