Client Name: _____

Lauren Hoyt, LLC
520-543-1700
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Informed Consent for Individual Psychotherapy

Purpose of Treatment

The purpose of individual counseling or psychotherapy is to produce change. Change encompasses helping you to deal with stresses and concerns in your life, to achieve your personal goals, and to improve your relationships with significant others. _____initials

Types of Therapeutic Approaches

General Procedures: In helping you to make changes, I will focus with you on your cognition or thinking, your emotions, your behavior and your relationships with others. I will primarily utilize talk therapy, although I may provide EMDR, hypnotherapy, PACT where ask you to engage in role playing, or assign homework. Although I provide individual, group, couples, family, and group therapy in my practice, this consent is for me to provide individual psychotherapy to you.

At times during the course of treatment, I may recommend adjunctive therapy. This may include referrals to a psychiatrist, your primary care physician, support groups, or other therapists as part of your therapy with me. If another health care provider is working with you I require that you sign an Authorization to Release Information so that I can communicate with that person about your care. _____initials

Potential Benefits: Counseling can help you acquire tools to develop your own solutions as well as learn how to deal with the difficulties in your life. _____initials

Limitations and Potential Risks: A "cure" is not guaranteed. As your therapist, I will provide you with the highest level of professional treatment commensurate with my training and experience. Psychotherapy calls for a very active effort on your part. In order for therapy to be successful, you will have to work on the things we talk about during our sessions and at home.

Therapy can involve discussing unpleasant aspects of your life and/or you may experience uncomfortable feelings. If I propose a specific technique (e.g., EMDR or hypnotherapy) that may have special risks attached, I will inform you of that and discuss with you the risks and benefits of that particular technique.

You normally will decide when therapy will end. However, there are exceptions. If in my judgment, I am not able to help you because of the kind of problem you have or because my training and skills are not appropriate for you specific issues, I will inform you of this fact and refer you to another therapist who may better meet your needs. If you engage in verbal or physically violent behavior, or threaten to do so to myself, office staff, or my family, I reserve the right to unilaterally and immediately terminate your treatment. Should this occur, I will offer referrals to other treatment providers. _____initials

Client Name: _____

Confidentiality

In general, the privacy of our therapy sessions and communication is protected by law; I can only release information about you to others with your written permission. **Please read the HIPAA handout. It is imperative that you read and understand the limits of privacy and confidentiality before you start treatment.** _____initials

Limits of Confidentiality: State and Federal laws limit confidentiality in situations in which there is a real or potential danger to you or others, when a court issues a subpoena or when child or vulnerable adult abuse or neglect is involved. There are other circumstances when information may be released including, but not limited to when disclosure is required by my licensing board (the Arizona Board of Behavioral Health Examiners), when a lawsuit is filed against me, to comply with worker compensation laws, to comply with the US Patriot Act, or to comply with other federal, state, or local laws. _____initials

Coverage by Other Therapists: Occasionally when I am unavailable or out of town for an extended period, I may have another licensed therapist on call for me. I reserve the right to disclose confidential information from your records to this on-call therapist in order to facilitate coverage of your care in my absence. Any such therapist is bound by the same laws regarding confidentiality as am I. _____initials

Electronic Tools: Please be aware that I utilize a number of electronic tools in my practice: computers, the Internet, e-mail, voice mail, and telephone. I will utilize reasonable back-up, security, and other safeguards to protect your information. However, there is always some risk of inadvertent disclosure of information that comes with using such tools. _____initials

Consultation: Consultation is a process in which selected cases are discussed in order to facilitate my continued professional growth and to get you the benefit of a variety of professional experts. The dynamics of the problems and the people are discussed along with treatment approaches and methods. In consultation, I try to avoid specific identifying information about clients such as names. In some situations, I may ask an expert to review your clinical record. In such cases, the expert is bound by the same laws regarding confidentiality as am I. By signing this document, you acknowledge that you have an understanding that I may use your "case" for consultation purposes. If you have any questions regarding this topic, please feel free to discuss them with me. _____initials

Records

The laws and standards of my profession require that I keep treatment records for six years. All client records are the property of Lauren Hoyt, LLC. You are entitled to receive a copy of your records, or I can prepare a summary for you instead with your written authorization. If you request to obtain your records or request them to be given to a third party, you must sign an Authorization to Release Information form. I will not video and/or audio record any of our session without your written consent. By initialing and signing this document, you also agree to not video and/or audio record without my consent as well.

Because they are professional records, they can be misinterpreted by untrained readers Therefore, it is highly suggested that initially we review them together or they be sent to another mental health professional so that you can discuss them with that professional.

Client Name: _____

In the event of my death retirement, or incapacity, the clinical records for my clients who are actively receiving services (seen within the past month) will be given to Solace Psychological Services/Dr. Shannon Sticken to facilitate the continuation of treatment. In such a situation, you may choose to continue treatment with a therapist at Solace Psychological Services, discontinue treatment, or ask for a referral. Records for my inactive clients will be handled by Solace Psychological Services as well, which will be responsible for satisfying records requests and destroying records when the legal time frames for records retention are satisfied.
_____initials

Treatment Decisions

Participation in Treatment Decisions: Our first 3-5 sessions will involve evaluating your needs and clarifying the goals of your treatment in determining whether I am a good fit as your therapist. We will then develop a written treatment plan that will outline our agreed upon goals for treatment, and the methods of treatment. We will review the treatment plan as needed (minimally once per year, per Arizona statute) to ensure that we are meeting your treatment needs. The treatment plan will be revised as needed to reflect changes in our goals and treatment records. You have the right and obligation to participate in treatment decisions and in the development and periodic review and revisions of your treatment plan. _____initials

Right to Refuse or Withdraw Consent to Treatment: Your treatment with me is optional and you are free to limit or end treatment at any time. In general, there will be no consequences to refusing or withdrawing consent to treatment. Should there ever be a time that you believe that I have treated you unfairly or disrespectfully, please talk with me about it. I want to address any issues that might get in the way of therapy as soon as possible. This includes administrative or financial issues as well as clinical issues. _____initials

Professional Fees

Fees for therapy are determined by the length of the session. A 50-60 minute session is $120. An 80-90 minute session is $165. **Payment is due at the time the service is rendered.** There are no refunds. Other services that will be billed at $120/hour include report writing, telephone calls lasting longer than 15 minutes, attendance at meetings with other professionals which you have authorized, travel, and other expenses incurred. Any therapy which you and I have agreed in advance is necessary to conduct telephonically or via Skype will be billed at the same rates as face-to-face therapy and must be paid in advance of the session. Should I be subpoenaed to serve as a witness of fact, I will charge $360/hour, including travel time. I reserve the right to change my fees with a 30-day notice. _____initials

Insurance Reimbursement

Payment is due at the time of service. I do not accept insurance assignments or bill any insurance companies. If you choose to attempt reimbursement by your insurance company, it will be your responsibility to know what mental health services your insurance policy covers. If you plan to submit for reimbursement on your own, you may discuss with me a diagnostic code and/or superbill, which may be required by your insurance company.
_____initials

Client Name: _____

Contacting Me

I am often not immediately available by telephone as I may be with another client or out of the office. When I am unavailable, my telephone is answered by voice mail that I frequently monitor. I will make every effort to return your call within one business day.

Contact with me via e-mail is for the purpose of scheduling and confirming dates and times of appointments only. I do not give advice or provide therapy via e-mail. There are no exceptions to this policy. If you contact me in this way, I will suggest that you schedule an appointment. If you choose to communicate information to me via e-mail, I will assume that you have made an informed decision and I will view it as your agreement to take the risk that the communication may be intercepted. In the event of a crisis, you should call the Community-Wide Crisis Line at 520-622-6000. In the event of a life threatening emergency, immediately call 911 or go to the nearest emergency room. _____initials

Meeting Times

Regular attendance at your scheduled appointments is important for a successful outcome in therapy. Once an appointment is scheduled, you will be expected to pay for the session unless you provide 24 hours advance notice of the cancellation. If you have repeated late cancellations or missed appointments, you will be required to pay the full fee for missed sessions, and ultimately your treatment may be terminated. In addition, if you arrive more than 15 minutes late to an appointment, it will be considered a cancellation. If there are frequent cancellations, I may charge your credit/debit card directly.

Appointment availability varies with my client load. I reserve the right to limit my commitments of high-demand appointment times to any particular client in order to meet the needs of all my clients and to balance my workload. _____initials

Our Relationship

The client/therapist relationship is unique in that it is exclusively therapeutic. It is inappropriate for a client and therapist to spend time together socially, to bestow gifts, or to attend family or religious functions. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained. The initial 3-5 sessions are not only for assessment and development of treatment goals but also to determine if the client and therapist are a good fit in terms not only of treatment and expertise, but also personality.

During therapy, there may be reasons for which I refer you to another/other provider(s) or terminate my services. Some reasons for termination of services would include: a) my clinical services no longer serve your current clinical needs or interests, b) I identify a conflict of interest after treatment begins, c) a higher level of care is necessary for the success of your treatment and/or to maintain your safety, d) the current needs of your situation are beyond my specific area of expertise, e) you have an outstanding payment due on previous rendered services and we have discussed the issue of nonpayment, f) lack of communication and contact from client.

Client Name: _____

In the event that I do not have contact or communication from the client(s) for a period of 90 days, I will consider that you no longer intend to remain active in your treatment with me. As a result, the Consent to Treatment will automatically expire and your clinical file will be closed. At that time, I am no longer considered your treating therapist of record. If you would like to continue treatment at a later date, please contact me to discuss this further. _____initials

Consent for Evaluation and Treatment

Consent is hereby given for evaluation and treatment under the terms described in this consent document. It is agreed that either of us may discontinue evaluation or treatment at any time and that you are free you accept or reject the treatment provided. You attest that you have read the HIPAA NOTICE of PRIVACY PRACTICES (provided separately), and have had your questions about privacy and confidentiality answered to your satisfaction and additionally that you have had the opportunity to ask questions about any information provided in this consent document. The HIPAA NOTICE of PRIVACY PRACTICES is incorporated by reference into this document.

Signature: _____ Date: _____

For Office Use only

Verification that client has read and understands the Informed Consent for Individual Psychotherapy and the HIPAA Privacy Notice

Therapist Signature: _____ Date: _____