Catherine Kaplan, Ph.D., LLC

Informed Consent Contract (5/16)

Welcome! This form is intended to help you understand how the office works and how to optimize the effectiveness of your treatment. Please read the form in its entirety and sign below to indicate your acceptance of and agreement to the policies, as well as your consent to engage in treatment. Please do not hesitate to ask me any questions or address any concerns you may have.

1. **Appointments** are generally scheduled on a weekly basis until significant progress has been achieved. At that point, research indicates it is best to taper the frequency of the sessions to every other week, and eventually to decrease to "check-in's" or "booster" sessions once a month or so. We will discuss your needs during sessions. Appointments begin at the scheduled time and continue for 45 minutes. Please be on time for your session in order to have your full session.
2. **Confidentiality** refers to your right to privacy. Any information you share in session is held in confidence. If you need me to communicate with someone else, please discuss the need with me and you must sign a release form PRIOR to my sending out any information or speaking with another professional or other individual. Sometimes therapists will consult on a case in order to provide the best possible treatment. In this case, your identity will remain confidential.
3. **Exceptions to Confidentiality** are few. Generally, confidentiality is breached when I have a legal and ethical responsibility to notify the appropriate agencies if you appear to be a danger to yourself or others (such as the intent to commit suicide or if child abuse/neglect has been shared). In this practice, these circumstances occur very rarely.
4. **Contact outside of session** usually occurs for the purpose of scheduling appointments. To schedule appointments, you may call or email me. **EMAIL IS NOT A SECURE AND CONFIDENTIAL FORM OF COMMUNICATION AND IS TO BE USED <u>ONLY</u> FOR SCHEDULING APPOINTMENTS OR TO REQUEST A RETURN PHONE CALL.** No therapeutic issues may be discussed via email. If a phone call is required, please indicate when you may be available for a return call. I will do my best to call you back quickly, Monday through Friday. If you are having an emergency and do not receive a phone call back in a timely fashion, please either call 911 or go to the nearest emergency room.
5. **Fees** are payable each session by cash, check, or major credit cards. There is no charge for appointments cancelled **at least 24 hours in advance**. You may leave a message canceling your appointment either by phone or by email. However, if you cancel on your appointment day, or fail to keep an appointment, you will be expected to pay for the missed time, except in cases of emergency.
6. **Phone call charges will be incurred** for telephone calls that exceed 10 minutes. You will be charged for the actual time (over 10 minutes) spent on non-emergency phone calls, reports and/or letters you request, with the fee based on your regular per session fee.
7. I do not believe it helps our therapeutic relationship to expect me to testify in court. Therefore, please realize that in signing this agreement you are agreeing that I will not be asked to testify in any court case in which you may become involved, and you will not give your attorney permission to subpoena my records.

8. I accept only Penn Behavioral Health and Medicare insurance. I will give you receipts you can submit to other insurance companies that reimburse for out-of-network providers. However, your insurance company is not likely to reimburse you for sessions missed with less than 24 hours notice or for telephone therapy sessions.

9. My therapist is hereby (please circle one) **authorized / not authorized** to provide information over and above diagnosis and dates of sessions to my insurance carrier, HMO, EAP or PPO plan, if I decide to file for third party reimbursement. I understand that answering questions asked by the insurance carrier requires release of otherwise confidential data. If reports are requested, time for special preparation will be billed to the client.

10. In the event of the incapacitation of your therapist, your signature here gives permission to transfer your records to another well-qualified therapist.

INFORMED CONSENT AGREEMENT

I have read this Informed Consent Agreement, the Office Policies form, and received a copy of the Notice of Privacy Practices. My signature indicates that I understand the information, agree with the conditions of psychotherapy that are either stated or implied here, and agree to comply with them. I understand I have the right not to sign this form and can choose to discuss my concerns before psychotherapy begins. I understand that once psychotherapy begins, I still retain the right to withdraw my consent to participate at any time.

If the consent relates to services for your minor child, and if only one parent or legal guardian signs below, your signature shall constitute an affirmative representation of your full legal authority to sign this consent of a non-signing parent or legal guardian.

_____

Client Signature Date

_____

Client Signature Date

_____

Parent Signature (If client is under 14 years of age) Date

_____

Parent Signature (If client is under 14 years of age) Date

_____

Therapist Signature Date

After completion of your therapy or after an extended absence, may a brief follow-up questionnaire be sent to your home so that you can share with me your opinions of what worked well and what was not as helpful to you during our time working together?

YES _____ NO _____ Signature: _____Date _____