The Journey Center for Healing Arts
2700 South Roan Street, Suite 410 Johnson City, TN 37601 Ph: 423-408-8041

Informed Consent

This is an opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies. Your therapist will answer any questions you have regarding any of these policies.

Purpose and Aims of Therapy

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness, personal growth, and self understanding
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals. Significant life/emotional issues may arise during the process. You can choose whether to address these further or not.
3. In the event that significant issues arise or goals change, please discuss your options for incorporating this into your ongoing work with me. Communication is key!
4. Identifying personal treatment goals.
5. Promoting wholeness through counseling, creative enhancement, music-centered psychotherapy, psychological and spiritual healing, and interpersonal awareness and growth.

You are responsible for providing all necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. Your therapist may ask you to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session.

Qualifications and Professional Background of Your Therapist

The specific qualifications can be found on your therapist's Professional Disclosure Statement.

Appointments

Appointments are usually scheduled for 55 minutes. Longer sessions of 60-90 minutes are scheduled in advance, as necessary and appropriate for the work needed in session.

Office hours are Monday – Friday 10am – 6pm, by appointment only.

The office is not staffed continually; if you need to drop off a payment, paperwork, or other item, please do so during sessions, or send through the mail to: 2700 South Roan Street, Suite 410 Johnson City, TN 37601.

Clients are generally seen weekly or more/less frequently as acuity dictates, and as agreed upon before scheduling the next appointment.

You may discontinue treatment at any time; please discuss any of these decisions with your therapist, before taking action, to help with transitions.

An accumulation of 3 missed appointments within a year will result in a referral to another provider who can accommodate this kind of flexibility.

Your therapist may suggest that you consider seeking additional support and refer you to a qualified professional. It is always up to you whether you follow through or not.

Your therapist will be available to you between sessions for brief supportive contact, as needed. The office is not staffed 24/7, but your call will be returned in a timely manner, within 2 business days. In the event of an **emergency**, call the local crisis line, your primary care physician, call 911, and/or visit the local hospital emergency room immediately. After reaching one of these professionals, you agree to contact your therapist by phone immediately and leave a message about the crisis and schedule a follow up appointment.

Confidentiality and Privacy

All of our communication is part of the clinical record, which is accessible to you upon request. A clinical chart is maintained describing our communication, your condition, treatment and progress in treatment, dates, fees and payment for sessions, and notes describing each therapy session.

Issues discussed in therapy are important and are generally legally protected as both confidential and “privileged.” No part of your identity, treatment, or story is shared outside of the therapeutic relationship. However, there are limits to this privilege of confidentiality. The limits of this confidentiality are:

1.) indication of abuse or neglect of a child, elderly person or a disabled person
2.) when your therapist believes you are in danger of harming yourself or another person, or you are unable to care for yourself
3.) if you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as the legal authorities
4.) if your therapist is ordered by a court (a subpoena is not a court order) to release information as part of a legal involvement
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 unintentionally
7.) when processing payments that are made by check/credit/debit, with the processing company and bank
8.) when you direct me, in writing, to disclose information to a third party

Other considerations of confidentiality:

Your therapist has an electronic record keeping system. All Electronic Health Records systems in use are HIPAA compliant.

Communication outside of the office is not considered fully confidential. We take extra precautions to keep this side of communication confidential and HIPAA compliant. When you give permission to communicate by email, voicemail, or text, you acknowledge that communication in this manner may not be fully confidential. It is your right to engage or disengage from communication in this mode at any time.

We participate in professional educational activities and supervision to improve our skills or to teach others. While engaging in this, we may discuss aspects of your process with other qualified professionals, with the understanding that no identifying information will be released without your written permission.

In case your therapist is suddenly unable to continue to provide professional services or to maintain client records due to incapacitation or death, we have designated a colleague, who is a licensed counselor, to be the professional executor of our work. The professional executor will be given access to all of the client records and may contact you directly to inform you of my death or incapacity; to provide you access to your records; and/or to facilitate continued care with another qualified professional if needed.

Financial Responsibilities

Therapy sessions are 45 or 55 minutes in length, for a fee of $100 or $125, respectively, payable by check, card, or cash.

We take a variety of insurances, including BCBS, Optum, Humana, Aetna, Tricare, ComPsych, Cigna, MedCost and Medicare. Check with your insurance plan to verify benefits and eligibility of coverage with your individual therapist.

Copayments or full payments are due at the time of service, unless other arrangements have been made before your appointment.

Insurance policies are an agreement between you and your insurance company. We are happy to maintain or seek credentialing with local insurance companies and file claims in and out of network, as a courtesy to you. We will try to help resolve any problems within our control. It is your responsibility to familiarize yourself with the process of Out-of-Network benefits, and to resolve issues beyond our control. If

insurance problems persist for an unreasonable amount of time (35 days from time of service), you will be responsible for full payment (60 days from time of service).

When engaged in the therapy process, the use of a mental health diagnosis can be helpful in identifying issues and treatment options, and is mandatory when filing for insurance reimbursement. This becomes a permanent part of your record. Not all issues have a diagnosis, and not all diagnoses are reimbursable by insurance.

Supportive contact between sessions, for reasons other than scheduling, will be charged at a prorated of $125/hr if the contact takes more than 10 minutes. This contact is not reimbursable by insurance.

Your medical records are available to you, at your request. Your record is also available to your insurance company at your approval. Occasionally, forms, letters of recommendation, treatment approvals, and coordination of care are required. The administrative fee for these requests is $50 per request.

Appointments scheduled but not kept, and not cancelled within 36 hrs of the scheduled time, will be charged $65, due within 30 days of the scheduled appointment. You can leave a voicemail, text, or email at any time to request to reschedule your appointment. This fee will be waived in the case of personal or family emergencies, if discussed with your therapist prior to the missed appointment. Fees will not be waived for appointments missed without any prior contact.

We do not attend court cases for divorce, child support, or custody. In the event that a court appearance is mandatory, the court appearance fee is $850 for court preparation and testimony. This fee is not reimbursable by insurance.

Professional Relationship and Ethics

You understand that we have agreed to abide by the code of ethics of the American Counseling Association, Social Worker Code, and the Association for Music & Imagery. An important aspect of the ethics is to maintain appropriate right relationship between you and your therapist. Your therapist will remain professional at all times, acting respectfully and mindful of your individual autonomy and best interests. You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, myself, or any office policy please inform me immediately to discuss the situation. We encourage you to discuss any concerns with your therapist, but are able to file a complaint with the state board organization against me if you determine that your therapist has violated any of the Code Of Ethics (www.counseling.org/Resources/aca-code-of-ethics.pdf).

Consent to Treatment

_____ To process this and future claims and fees, I authorize the release of any medical or other information necessary, to my insurance company or person/entity responsible for payment:

Insurance Company:_____

ID #: _____ Group #: _____

Phone #: _____

_____ I authorize payment of government benefits and medical benefits to my therapist for services described in claims.

_____ I release all information pertaining to my mental health treatment to my emergency contact person:

_____

Phone #: _____ Relationship:_____

Appointment reminders, and communication related to my care, are authorized by

____ phone ____ voicemail _____ text Phone # _____

____ email _____

I acknowledge that I have read, understand, and agree to abide by the contents and terms of this professional disclosure document, and I have had all of my questions answered. I accept full financial responsibility for services and agree to pay, in full, within 30 days of scheduled service, any fee not covered by insurance. I voluntarily consent to participate in evaluation and/or counseling treatment.

_____ _____

Client Signature Date

_____ _____

Client Printed Name Client Date of Birth