 Practice Information and Consent for Treatment

**Practice Information**:

Koru Psychological Services, PLLC is owned and operated by Dr. Melissa Flint, Psy.D., CT, CCTP. I share space with other providers of psychological services, but we are separate business entities. My practice is currently limited to those experiencing issues related to grief and loss. Therapy is work – it takes time, energy and a willingness to look at things from all different angles to figure out the best way for you to move forward. Psychotherapy calls for active participation of both you (the patient) and I (the psychologist). The more honesty and truthfulness you are able to bring into our time together, the more likely the positive outcome of our time together.

The first few sessions will consist of an evaluation your needs. By the end of that evaluation period, I will be able to offer you my impressions and work with you to develop a plan to meet your needs. You are also evaluating me during this process. I want us to be a good fit, but that is unlikely to always happen. Additionally, I find that some clients might want to quit therapy when they have found a topic difficult to discuss. I do ask that we talk, face-to-face in session about ending your therapy. Therapy is a huge commitment – both financially and in time required. If it turns out that I am not the best fit for your needs, you will be provided with referrals to clinicians who might be better suited for your particular needs.

**Risks and Benefits:**

Psychotherapy involves discussing unpleasant aspects of life. People might experience feelings like sadness, guilt, anger, hopelessness, frustration, among other feelings. Psychotherapy has been shown to have benefits. If we are better able to understand relationships, solutions to our problems, cope with our grief and loss, we often have a reduction in negative symptoms. There are no outcome guarantees.

**Appointment Information:**

My assessment usually occupies the first session, and depending on the complexity of your case, may last for several more sessions. During our time together we can decided if I am the best person to help meet your goals. Once we begin psychotherapy, our sessions consist of one appointment hour (45-50 minutes). ***Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation***.

If you arrive late for service, the service will end at the regularly scheduled time and may be shortened as a result. As you have booked the entire therapeutic hour, the fees for the time will not be pro-rated. If I begin a service late due to an emergency, you will receive the full length of the service. In rare cases, if my doctor is late and cannot accommodate this, I will be credited for unused time or will receive a future extended session.

**Professional Fees:**

My hourly fee is $150/ hour for an intake session and $135 per hour for a 45-50 minute therapy session. I charge this amount for other professional services rendered, and will break down the hourly cost if I work for periods less than one hour. These services may include report writing, telephone conversations lasting longer than 10 minutes in duration, consulting with other professionals with your permission, preparation of records and/or treatment summaries, or other professional services that you might request. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs.

**Contacting Me:**

Due to my varied schedule, I am most often not immediately available via phone. When I am not available, I have a confidential voicemail that I monitor frequently. Please leave your name and phone number (even if you think I have it). There are many times I will return calls without your physical file in front of me, therefore, I require your phone number. If you are unable to reach me, but feel that there is an immediate crisis, please reach out to your primary care physician, the nearest emergency room or 9-1-1 as appropriate. Please note that I may forward my office calls to my cellular phone. Additionally, I will make every effort to inform you in advance of any planned absences from my practice which may affect your ability to schedule with me.

**Limits of Confidentiality:**

I will treat what you tell me with great care. My professional ethics (that is, my profession’s rules about values and moral matters), and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about. This is the “confidentiality” in therapy.

In most cases, I can only release information with your written authorization. There are other situations that require that you provide written, advance consent. Your signature on this Consent for Treatment provides consent for the following activities:

1. I may find it helpful to consult other medical and mental health professionals about a case. During this discussion, I make all efforts to avoid revealing the identity of my client. The people to whom I speak also hold this same responsibility for confidentiality during consultation. I will note all consultations in your clinical record.

There are some situations where I am legally obligated to take action which I believe are necessary to attempt to protect others from harm and I may have to reveal information about a patient’s treatment. These situations are unusual in my practice, but nevertheless, could occur.

1. If I come to believe that you intend to do serious harm to another person, I am required to try to protect that person. I may have to tell the person, the police and possibly have you hospitalized.
2. If you seriously threaten or act in a way that is very likely to harm yourself, I may have to call on your family members or others who can help protect you or seek to hospitalize you. If such a situation does come up, I will try to discuss the situation with you fully before I do anything.
3. If I believe or suspect that you are abusing a child, an elderly or disabled person, or another vulnerable person, I must file a report with the appropriate government agency (in Arizona this is the Arizona Department of Child Safety). Once the report is filed, I may be required to provide additional information.
4. If I have reason to believe that any adult patient who is vulnerable and/or incapacitated and who has been a victim of abuse, neglect or financial exploitation, the law requires that I file a report to the appropriate state official (In Arizona, this is Adult Protective Services, a part of the Arizona Department of Economic Security). Again, I may be required to provide additional information as a part of this report.
5. In an emergency where your life or health is in danger, and I cannot get your permission, I may have another professional some information to protect your life. I will try to get your permission first, and I will discuss this with you as soon as possible afterward.

In any of these situations, I would reveal only the information that is needed to protect you or there other person. I would not tell everything that you have told me.

In addition, there are limitations and risks in contacting your therapist through electronic media (i.e. email). Email, Skype and other sources of e-communication may not be secure nor confidential. Note that any emails sent to the practice may be retained in the logs of the Internet service provider. Emails received from you will be printed and kept in the treatment record. Any reports sent via e-mail will be password protected. You have the right to refuse to receive reports via e-mail. You understand the risks and limitations of email transmissions. Please see my Social Medical Policy on the website for specific information regarding electronic platforms.

**Billing and Payments:**

You will be expected to pay for each session at the time it is held. Payment for services will be collected at the end of the session. The following forms of payment are accepted: cash (exact amount only), personal check, Visa, Master Card. You will be charged a $30.00 fee for a payment returned for any reason.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient’s treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, the costs will be included in the claim.

**Conflict of Interest and Multiple Relationships:**

If, during the course of our therapy together, I discover that our therapy represents a conflict of interest in which I am required to fulfill 2 simultaneous roles (i.e. therapist and educator), I may need to withdraw from my therapeutic roll and provide you with several recommendations for other mental health professionals.

**Right to Refuse Service:**

I maintain the right to refuse services to clients at any time. In the event that a client presents to therapy under the influence of any substance, the session will be cancelled and s/he will be responsible to pay for the cancelled session. In the event that I feel that my safety is endangered, I reserve the right to terminate therapy and present the client with several recommendations for other professionals.

I acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with the therapist. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand and agree to play an active role in the therapy processes.

I understand that no promises have been made to me about the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. If I do, I will have to pay for the services I have already received.

I know that I must call to cancel an appointment at least 48 hours (2 business days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that Dr. Flint does not accept insurance at this time. This is a cash pay practice.

My signature below shows that I understand and agree with all of these statements.

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Signature of client or legal representative  Printed name            Date

Printed name of legal representative    Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

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Signature of therapist                     Date

□ Copy accepted by client  □ Copy kept by therapist