

INFORMED CONSENT FOR PSYCHOTHERAPY

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in the process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that want for yourself.

Confidentiality

The session content and all relevant materials will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items # and #4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering a n expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name. If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly to you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

SIGNATURE: _____ **DATE:** _____

4. Standard Intake Questionnaire

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

(check all that apply)

- Anxiety
- Appetite Issues
- Avoidance
- Crying Spells
- Depression
- Excessive Energy
- Fatigue
- Guilt
- Hallucinations
- Impulsivity
- Irritability
- Libido Changes
- Loss of Interest
- Panic Attacks
- Racing Thoughts
- Risky Activity
- Sleep Changes
- Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grow up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

Alcohol

Tobacco

Marijuana

- Hallucinogens (LSD)
- Heroin
- Methamphetamines
- Cocaine
- Stimulants (Pills)
- Ecstasy
- Methadone
- Tranquilizers
- Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want the doctor to know?:

GROVE CITY PSYCHOLOGICAL SERVICES
CREDIT CARD AUTHORIZATION
NO SHOW/LATE CANCELLATION FEES
INSURANCE CO-PAYS & DEDUCTIBLES
THERAPY FEES

Effective 1/1/2022 In order to provide you and other patients of Grove City Psychological Services the best possible care, a minimum of 24 hours' notice is required to cancel or reschedule your appointments.

I, _____ understand the importance of notifying Grove City Psychological Services at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. I understand that I will be charged a LATE CANCEL fee, or a NO SHOW fee failing to call within 24 hours or failing to show for my scheduled appointment.

FEE SCHEDULE:

\$75 failed missed appointment

I, _____ give Grove City Psychological Services the authorization to charge my credit card for each missed therapy session where I failed to call or failed to show up for the appointment. This card will also be used for all fees that have not been paid within 30 days (unless other arrangements for payment have been agreed upon in writing between me and my therapist). I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payments, deductibles, and fees).

Name on card _____

Card #: _____ - _____ - _____

Exp Date: _____ / _____

CCV Code: _____

Zip Code: _____

Parent/Guardian/Card Holder Signature: _____

Date: _____