INFORMED CONSENT AND PRACTICE POLICIES-(Adult)

General Information

The therapeutic relationship is unique in that it is a highly personal experience and at the same time, operates within the context of a formalized agreement. Based on the nature of this agreement, it is important for us to reach a clear understanding about how this process will work, and what each of us can expect. This informed consent and related practice policies document will provide a framework for our therapeutic work together. Please feel free to discuss any of the contents of it with me at any time.

Therapeutic Process

The psychotherapy process can be very beneficial in many capacities, but as with any type of treatment, there are risks. During therapy, we may have discussions about personal situations that could trigger uncomfortable emotions (e.g. sadness, anger) and/or possible periods of struggle. I will do my best to continually support you throughout the process, however, it will also entail an active effort on your part to work through areas that we discuss both inside and outside of sessions. While there are no guarantees about the positive outcomes of psychotherapy, it can often lead to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems.

Confidentiality

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

1. If you threaten or attempt to commit suicide or otherwise conduct yourself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If you threaten grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that you 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 #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If you are in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

At times, I may also seek consultation with other professionals in their areas of expertise as a means to provide the best treatment for you. Information about you may be shared in this context without the use of your name or other related identifying information.

If we happen to see each other outside of the therapy office, I will not initiate acknowledging 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 then reciprocate and acknowledge you as well. As a means to maintain the integrity of the therapeutic process, I will not engage in any lengthy discussions in public or outside of the therapy office.

Appointments and Cancellations

Individual and/or family therapy appointments will be approximately 45 minutes in length and will occur once per week (or more/less frequently as indicated) at a mutually agreed upon time and group therapy appointments will be approximately 60 minutes in length and occur once per week (if applicable). The time scheduled for your appointment is reserved exclusively for you and in the event that you need to cancel or reschedule a session, I ask that you provide me with at least 24 hours notice. If you do not show up for a scheduled session or cancel a scheduled session by providing less than 24 hours notice, you will be responsible for the full session fee. It is also important to note that insurance companies do not provide reimbursement for no show situations or late canceled sessions; thus, you will be responsible for the session fee as described above. In addition, you are responsible for arriving at your session on time to ensure that we can meet for the full duration of it; if you are late for the session, the session will still need to end on time.

Telehealth (Video/Online) Therapy

Telehealth involves the use of telecommunications technology to provide real time therapy at a distance. Telehealth can be delivered via video-conferencing through the use of desktop computers, laptop computers, mobile phones or tablets. As a means to protect your confidentiality via telehealth, I use a secured, encrypted, HIPAA compliant telehealth platform (Simple Practice or Google Meet). Due to the technical nature of telehealth, there may be issues with internet connectivity at times whereby internet availability may be limited or disrupted. In the event that the internet connection is disrupted for an extended period of time, the session can be resumed by telephone or via telehealth at another time if necessary.

Telephone Access

If you need to contact me between sessions, please leave a message on my voicemail. I am not always immediately available; however, I will make every effort to return your call on the same day or within 24 hours. If a true emergency situation arises, please call 911 or any local emergency room.

Electronic Communication

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I make every effort to return messages in a very timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss

therapeutic content and/or request assistance for emergencies. As it relates to electronic communication, services by electronic means include but are not limited to text messages, email, the Internet, and fax machines.

Social Media

As a means to preserve your confidentiality, maintain therapeutic boundaries, and minimize the possibility of any dual relationships, I do not accept friend or contact requests from current or former clients on any social networking sites (Facebook, Instagram, LinkedIn, etc).

Insurance

I am currently an in-network provider for Cigna and am out-of-network with all other insurance providers. If you have out-of-network benefits through your insurance provider, I can furnish you with a monthly statement for services, which you can submit to your insurance provider for reimbursement. In some situations, I can also handle the process of submitting out-of-network insurance claims on your behalf. Please note that not all insurance companies reimburse for out-of-network providers.

Professional Fees

Fees are based on the nature of the service that is being provided (e.g. individual therapy, group therapy, family therapy, consultation, supervision, etc). We can discuss the details of the fees when we speak on the phone prior to the first appointment and/or when we meet in person. In some situations, I can also accept sliding scale payments based on personal circumstances. Payment of fees will be due at the time of your session unless prior arrangements have been made. Payment can be made by check, cash, EFT or credit card. Any checks returned to my office are subject to an additional fee of up to $35 to cover the bank fees that I incur. In additional specific situations, there may also be charges for other professional services that are requested such as report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings, or the time required to perform any other additional services which you may request of me.

Consent To Psychotherapy

Your signature below indicates that you have read the complete contents of this Informed Consent and Practice Policies document as well as the attached HIPAA Notice of Privacy Practices (which does not need to be signed separately) and agree to their terms. Your signature below further indicates that you authorize Zachary Schwartz, MSW, LCSW, LLC to provide psychotherapy services to you.

Client Name (printed): _____

Client Signature: _____

Date: _____