OUTPATIENT MENTAL HEALTH INFORMATION & CONSENT TO TREAT

Confidentiality: All information obtained in the course of the therapeutic relationship is fully confidential. In order to share this information, you will have to sign a release of information form. Exceptions to this include safety-related issues where (a) a client is a clear danger to him/herself or (b) a client is a clear danger to someone else or (c) a client is a minor (under the age of 18) and either reports or it is suspected that s/he has been a victim of physical abuse, sexual abuse, and/or neglect (d) or as ordered by a court of law.

Therapist Contact Between Sessions: You may call or email the therapist between sessions for brief questions, concerns, or scheduling matters. We are not always able to answer the phone, so please leave a voicemail and we will make an effort to return your call within 48 hours. **In the event of an emergency, please contact your designated crisis intervention services (Lancaster County 717-394-2631, Lebanon 717-274-3363, or Dauphin County 717-232-7511), dial 911, or visit your local emergency room.**

Cancellations require twenty-four (24) hours advance notice: We request 24 hours advance notice for cancellations. When an appointment is scheduled, that time is reserved for you. Due to high patient demand and the limited availability of appointments, any missed appointments could likely result in a disruption of future appointments. Cancellations made prior to this window are rescheduled with no penalty. **No-shows and late cancellations made without 24 hours notice may incur a $45 late cancellation fee.**

Length of Session: A routine psychotherapy session is 45-50 minutes in length. Time between appointments is used to complete required paperwork and return professional phone calls.

Payment is due at the time of service: All fees must be paid at the time of services. If you do not pay at the time service is rendered, your next appointment may be rescheduled until the balance is paid in full. If a parent or another party takes responsibility for payment, the client is still required to bring that payment to the appointment. At the time of payment, you will receive an invoice for services that contain all information necessary for you to submit to your health insurance if needed. Financial responsibility is expected, because it maintains the integrity of the therapeutic relationship. If you have any concerns about meeting these obligations, please discuss it with your therapist.

Able to accept cash, checks, Visa/Mastercard: A $30 service charge will be assessed for any checks returned by a financial institution for insufficient funds. After two (2) consecutive returned checks, your therapist reserves the right to require all future payments to be made in cash or credit card.

Termination: The ending of the therapeutic relationship is an important process. Your therapist will discuss termination with you during a routine appointment.

Your records: Records are kept at the office for a period of six years after the age of 18 years have been reached, at which time they will be shredded.

Legal/Court Involvement: If you enter into treatment with us, you are agreeing not to engage Treehouse Counseling Staff in legal/court proceedings or to attempt to obtain records of treatment for legal proceedings. This prevents misuse of your treatment for legal objectives. Our goal is to support you in achieving therapy goals, not to address legal issues that require an adversarial approach.

Protected Health Information (PHI): For information about how your therapist may use and disclose your protected health information, please refer to your copy of the Notice of Privacy Practices (NPP). The treatment you will receive is bound by the "Notice of Privacy Practices". Your therapist will only discuss information to outside sources upon written request by the client/guardian. If a client has any questions and/or concerns regarding privacy or confidentiality, the client understands that he/she will discuss these questions/concerns with the therapist. The longer version of the NPP is available upon request.

Treatment Philosophy: Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally, individuals may go through periods in therapy which result in emotional discomfort, changes in relationships or temporary worsening of their symptoms. This should subside as the work progresses. You will always retain the right to request changes in treatment or to refuse treatment at any time.

I CONSENT TO RECEIVE TREATMENT for counseling services for myself or my child from Sandcastle Counseling. Signatures(s) below indicate that I/we have read and understand the above consent to treatment under the conditions specified above. I/we specifically authorize the release of my clinical record information to Sandcastle Counseling for coordination with my insurance company for the purpose of payment. In the event that treatment is for a minor child (under age 14), I hereby give my consent to treatment and affirm that I am their legal guardian with authority to authorize mental health treatment.

Client Name (Please Print) _____

Client/Parent/Guardian _____ Date: _____

Client/Parent/Guardian _____ Date:_____