

Informed Consent for Therapy

CONFIDENTIALITY

Everything you discuss and share in therapy is confidential. Information about your therapy will not be disclosed without your written permission.

EXCEPTIONS TO CONFIDENTIALITY

1. Kentucky laws require that abuse, neglect and exploitation be reported when the victim is 1) a child, 2) a domestic spouse/partner, or 3) an adult with a disability who is unable to protect him/herself.
2. If you are intending to take action to harm yourself (suicide) ... I will make every effort to enlist your cooperation to ensure your safety. If you do not cooperate, I may take further measures in order to ensure your safety.
3. If you are intending to take action to seriously harm (homicide) another person/s ... I will take action to protect potential victims.

ELECTRONIC COMMUNICATION

The confidentiality of any form of electronic communication cannot be assured. If you communicate confidential or private information via email, texts, e-fax or phone messages, I will assume that you have made an informed decision and view it as your agreement to take the risk of such communication.

Clients often conduct online searches about my practice and/or me. I do not search clients online or interact via Facebook or other social media unless necessitated by a clinical need to assure your well-being.

COMMUNICATION WITH PROFESSIONALS and RECORDS SHARING

To enhance your therapy I may confer with other providers and professionals and share confidential treatment information and/or records. I will do so only with your prior written consent. In those communications confidentiality is fully maintained.

COUPLES COUNSELING and "SECRETS"

A secret kept from a spouse/partner may undermine the relationship and success of therapy. I will not align with a secret ... and will instead work with the withholding individual to be forthright to repair and heal the relationship and rebuild trust.

ETHICAL CONDUCT and DUAL RELATIONSHIPS

I follow all guidelines and requirements of the AAMFT and Kentucky Code of Ethics for Marriage and Family Therapists.

Therapy never involves sexual or any other dual relationship that impairs objectivity, clinical judgment or can be exploitative in nature.

I will not acknowledge working with you to others without your permission.

It is your responsibility to advise me if any dual or multiple relationship becomes uncomfortable for you in any way. I will carefully consider your feedback and adjust any dual relationship interfering with the effectiveness of your therapy or welfare ... and, you can do the same at any time.

LITIGATION LIMITATION

Due to the contradiction between the healing intention of therapy and the adversarial nature of litigation, I do not participate in litigation or any other legal proceedings. It is agreed that neither you nor your attorney will call on me to testify in court, or request therapy records for litigation purposes, unless court mandated.

CONSULTATION

I consult regularly with other professionals regarding cases; in all instances client identity remains completely anonymous and confidentiality is fully maintained.

PROCESS OF THERAPY/FEEDBACK and SCOPE OF PRACTICE

Participation in therapy can result in a number of benefits, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits requires your active involvement, honesty, and openness in order to change your thoughts, feelings, and/or behavior. I will seek your feedback on your therapy, its progress, and will expect you to respond openly and honestly. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Change will sometimes be easy and swift, and it can be slow and at times frustrating. There is no guarantee that therapy will yield the intended results. During the course of therapy I will bring various approaches to address the problem being treated and what will best benefit you.

I may suggest or refer you to other providers with expertise to address specific concerns and/or assist in your treatment.

I am not a physician and do not prescribe medications.

I am not a psychologist and do not conduct psychological evaluations.

I do not provide legal or financial advice.

TERMINATION

You are free to terminate therapy at any time. On your request, I will provide you with names of other qualified professionals if you wish to seek other services.

Office Policies

FEE

Fee is \$95.00 per 50-55 minute session.

Payment is due at time of service. Preferred method is check made payable to "Craig Herink, LMFT". I also accept cash and major credit cards.

TELEPHONE & EMERGENCY PROCEDURES

If you need to contact me between sessions, please leave a message at (502) 640-2337 and your call will be returned as soon as possible.

No fee for routine phone calls up to 15 minutes to address scheduling and administrative matters. \$1.00/minute for calls beyond 15 minutes addressing therapeutic issues.

In an emergency if you cannot reach me directly:

- Call the Crisis & Information Center: (502) 589-4313
- Call 911

Do not use texts, email, voice mail, or faxes for emergencies.

CANCELLATION

Scheduling of an appointment involves the reservation of time specifically for you. A minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Except in cases of illness or emergency, or unless we reach a different agreement, the full fee will be charged for sessions missed without such notification.

HEALTH INSURANCE & CONFIDENTIALITY

I am not a contracted provider on any insurance panels and do not deal directly with any insurance plans. You may file a claim directly with your provider ... and may be able to get partial reimbursement if your insurance plan provides out of network coverage. If you request I will provide you with an Invoice you can use to submit a claim.

Submitting a mental health claim for reimbursement carries a certain amount of risk to confidentiality and privacy. I will assume that you have made an informed decision and view it as your agreement to take the risk of such action.

REDUCED SLIDING-SCALE FEE

Reduced sliding-scale fee services are available on a limited basis. Please ask if your financial situation merits a reduced fee.

I have read the above Informed Consent for Therapy and Office Policies carefully. I understand them and agree to comply with them:

Client Name (print) _____

Signature _____ Date _____

Client Name (print) _____

Signature _____ Date _____

Therapist Signature _____

