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Informed Consent for Counseling Services (01/01/2023)

Welcome to Caldwell Family Counseling, Bloomsburg, PA. The practice is owned by Denise Caldwell, LCSW. This letter is an agreement between Denise Caldwell, as an independent contractor at this office, and you for treatment and to inform you about the practice policies and procedures. I welcome questions – both now and throughout our time together.

General Communication and Emergencies

You may call the office number if you have any problems that may impact your appointments. Please leave a message (extension 2) and I will get back to you as soon as possible, usually one to two business days. My voicemail is confidential and password protected. On a rare occasion, a message may get lost.

If there is a mental health emergency on weekends, holidays, vacations, or sick days that I am unavailable, or after 5:00 p.m. until 8:30 a.m., that you feel needs **immediate attention**, please contact the Tapline number at **1-800-222-9016 for Columbia, Montour, Snyder, or Union Counties and 1-855-313-4387 for Northumberland County. (National Suicide Prevention is 988 or to chat <https://suicidepreventionlifeline.org/chat/> or the Trevor Project for LGBTQ individuals (866) 488-7386)** You may also go to the nearest emergency room or dial 911. **Do not leave a message by phone, text, or email if you have a mental health emergency, as I may not be able to get back to you immediately.** _____ **Please initial that you understand.**

You may call me between 8:30 a.m. and 5:00 p.m., Monday through Friday, with mental health concerns (excluding holidays and possible days off in which case I will leave a message on the answering systems indicating my exact days off and return date). For my clients, I do offer my business cell number to call me if you do need to reschedule or talk about a situation that is not an emergency but important to you. During those hours that I am available, please remember that I cannot always take a call immediately, but I will get back to you as soon as possible. I try to check my messages several times a day. If there is an immediate health or physical threat to your well-being, please contact 911 or your local police number.

If you are calling to talk about mental health issues and problems that bring you to counseling, please be aware that I will be charging you for the time that I am on the phone with you. **Texting is only for scheduling only.** Discussions about treatment issues will only be discussed on the phone or at sessions. You may schedule an extra session if time is available in our schedules. _____ Please initial that you understand.

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. Most of our communications are confidential, but the following limitations and exceptions exist: (a) you provide me with your consent to release specific information (please note that you may withdrawal any consent in writing at any time); (b) I have reasonable suspicion that you are a danger to yourself or someone else; (c) I have reasonable suspicion or there is disclosure of abuse (physical, sexual, emotional), neglect, or exploitation of a child, elderly, or disabled person; (d) responding to a complaint against another mental health professional due to ethical misconduct; (e) I am ordered by a court order to disclose information; (f) you involve me in a lawsuit; (g) I need to release specific information in order to receive compensation for services rendered; (h) I need to share specific and requested information with a parent/guardian about an adolescent or child (h) Your insurance company requests documentation of

your services with me. (i.)I am otherwise required by law to release information. _____ Please initial that you understand

The Counseling Relationship

In the beginning, we will be getting to know each other. I encourage you to view my website at www.cfc457.com where you can learn more about my training and education. I see our work together as a collaborative process, so I rely on your open communication with me to do my job well. Together we will pay attention to how you are progressing toward your goals, and how you are feeling in your communication with me as we go along.

I recommend that you make an appointment for a physical exam with your family doctor if you have not done so recently. Some problems that seem psychological may be medical or a medical condition may be making your problems worse. If you sign a consent form, I will consult with your doctor so we can all be working together toward your goals.

During the time we work together based on a mutually agreed upon schedule in sessions lasting approximately 50 minutes. If you are present at your scheduled appointment time and I do not come to the waiting room for you, you are welcome to knock on my office door after 5 minutes (room #5 off the waiting room). I may call/text you if you do not show for your appointment to understand what has happened in my or your schedule. A no show fee may be due based on the circumstances of your missed appointment.

Although our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one. Our contact will be limited to the counseling sessions. Please do not invite me to social gatherings, offer me gifts, ask me to write references for you, or ask me to relate to you in any way other than in the professional context of the counseling sessions. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. We can negotiate what would be best for you in those situations and this can be an ongoing discussion depending on circumstances. I will not, however, divulge the nature of our relationship. I will respect your wishes and follow your lead. We may need to discuss any complex or unexpected situations that arise for any reason during treatment that relate to any type of dual relationship.

Process of Therapy/Evaluation and Scope of Practice

Participation in therapy can result in several benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness to change your thoughts, feelings, and/or behaviors. I will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations which can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During therapy, I am likely to draw on various psychological approaches according to the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not limited to contextual systems/family, developmental (adult, child, family), humanistic and person centered, Eye Movement Desensitization Reprocessing (EMDR), Internal Family Systems model, and Intimacy from the Inside Out for couples' therapy and/or psycho educational. **I provide neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within my scope of practice.**

TREATMENT PLANS: Within a reasonable period after the initiation of treatment, I will discuss your working understanding of the problem, treatment plan, therapeutic objectives, and your view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used during your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. You also have the right to decline any services or treatment modalities and the consequences of such decline will be discussed with you. Treatment plans are updated every 180 days, but we can review progress or change/add goals whenever you request. You have a right to refuse any treatment plan goal you do not agree.

TERMINATION: If you or I believe that I am not a good fit for your needs, I can give you referrals that you can contact. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice to help with the transition. If at any point during psychotherapy I either assess that I am not effective in helping you reach the therapeutic goals, I will ask for your input, and we will work together to make sure that you are getting the help that you need. You have the right to terminate therapy at any time. I ask that you discuss this in advance so we can plan for closure and saying goodbye. I reserve the right to postpone counseling of clients who come to their session under the influence of alcohol or drugs, however, I would prefer to work with you on helping you to get the help you might want if this would be an issue for you. If at any time, there is an issue, I will come to you and discuss it with you and hopefully, we can come up with a plan to satisfy both our needs. _____ Please initial that you understand

Session Expectations

Your session is reserved for you. If you will be unable to keep an appointment, please notify my office at least 24 hours in advance, so that someone else may utilize this time. **In the absence of your notification, there may be a no-show fee of \$45.00 due before or at your next session (excluding Medicaid participants).** More notice is appreciated, as it frees potential openings for other clients. Exceptions to the 24-hour requirement are made for illness and dangerous driving conditions. _____ Please initial that you understand

I ask during this time of easing COVID infection, that you not come to your appointment if you are feeling ill. I will do the same. If I am feeling sick with mild symptoms, I will wear a mask and offer you one as well if you want one. Hand sanitizer is located around the offices for disinfecting after pen/paper handling, etc. If you do contract COVID, again, do not attend your appointment, follow the CDC or your work guidelines for quarantining, and/or return when your quarantine is done or switch to telemental health. Yes, you can choose to have a session via phone or Zoom. This is a safeguard that is always an option when you are sick or need to quarantine. Telemental health is also available as an option for sessions in general. Some people choose this method of meeting due to travel difficulties, schedules, etc. I will provide you with instruction and with a Telemental Health informed consent to help you understand the benefits and limits of telemental health if this is a preference for you.

There are times that we may have a missed appointment because you had it on the wrong day/time or I had it in the wrong day or time. I will offer you with a card or a text with your appointment written on it, if you request it but in general, I trust you to keep track of your appointment. In general, if you haven't attended a session in over 30 day, we may discuss it on the phone or, if I haven't seen or heard from you, I will send you a letter to ask for clarification and your intent on returning or ending treatment. I always want to take your circumstances into consideration. If you are no longer interested in continuing, please let me know. I may not be able to hold a time for you if those 30 days have passed. _____ Please initial that you understand.

Fees/Payment Expectations (State Medicaid insurance does not apply)

In return for the current fee, I agree to provide counseling services for you. If the fee is a hardship for you, please let me know. Cash, personal checks, money orders or VISA/Mastercard/American Express/Discover are acceptable. I may not be able to take Employee Benefit/flex spending cards but I will try to run the card and see what happens. I find I can take some but then others will not go through. I will

provide you with a receipt for your submission for reimbursement from your health insurance company if I do not accept your insurance. **The fee for each session, or the insurance co-payment for which you are responsible, will be due and must be paid at the end of each session.** Co-payments are part of the contract with the insurance company, and I must collect all co-payments to fulfill the obligation of that contractual agreement. In addition, if your insurance declines any payments, you will be responsible for those fees. _____ Please initial that you understand.

I do need to collect any unpaid balance left on your account. Please call and we can work on a payment plan. However, if there is no effort on your part to pay for services that you have received, I will be unable to provide services in the future until this balance is paid. _____ Please initial that you understand.

Insurance

This office accepts many forms of health insurance. However, I ask that you call your insurance provider prior to attending your first session to find out if I am on your insurance panel and what the conditions are for your co-pay, deductible, or co-insurance. You will want to ask how many sessions you are entitled to for the year. You will be responsible for the payment of the session if your insurance does not pay for the session(s). I will inform or bill you as soon as I have that information. Please remit your payment.

For billing purposes and for authorization of sessions, I may be required to submit information about you (symptoms, diagnosis, treatment plans, dates of attendance). It is against the law for insurers to release information about our office visits to anyone without your written permission. Although I believe the insurance company will act morally and legally, I cannot control who sees this information at the insurer's office.

E-mails, Cell Phones, Computers, Faxes and social media

I want you to know that most of your insurance billing is done online through secured insurance sites, however, there is always a risk to breaches of data not in our system. I follow the HIPAA and HITECH guidelines to ensure your confidentiality. This includes having my computer encrypted and password protected. My computers have a firewall, virus protection and are backed up regularly; this includes any electronic records that are kept as part of your file. If there is ever a breach with my security that might affect any of your confidential records, I will be informing you within in week when a breach has been discovered. All paper files are kept locked up for privacy and confidentiality.

Please know that texting, cell phone communication, faxes and emails are not always private for various reasons. If you communicate confidential or private information via unencrypted email, I will only respond with a secure, encrypted email message that may require that you set up a username and password. This is required due to HIPAA/HITECH law. I would use my landline phone and in person communication to ensure your privacy whenever I can. I also use texting for secure texting for appointment reasons and exchanging a minimum of information only. **Whatsapp** is an encrypted texting service and if texting is what you need, we can use this application for our texts. Please know that I print and keep copies of emails and text messages as part of your permanent file. **Please do not use texts, e-mails, or faxes for emergencies or discussion of your mental health issues but dial an emergency number listed under emergency information or contact me directly at the office or my business cell phone number.**

I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise your privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking websites. I do not conduct internet searches on you or your family.

Waiting Room Expectations

A courtesy reminder is to supervise your children in the waiting room and to not let them leave the area unattended. Please supervise your younger children in the bathroom to ensure that it remains clean after each use and they are not interfering with the other businesses that are housed in that part of the building. Thank you for your consideration and respect for this shared space.

Never bring a weapon to the office and if you have some need for security or safety, please discuss this with your therapist.

Please do not bring any pets to the office as a courtesy to other clients and their families unless it is a registered service animal. Off the kitchen area, is a bathroom on the right that you may use. There is coffee and tea for you in the kitchen area. Please help yourself or I can get it for you!

Court Appearances/Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon. I do not appear in court as it conflicts with my role that must maintain safety, trust, and clear boundaries from the legal system. I am not a custody evaluator, so it is not my role to speak to your custody issues in terms of who is fit as a parent. Many times, my clinical impressions could possibly create an unfavorable view rather than the one you may be looking for against a spouse, partner, grandparent, etc. I must remain multi-partial to all family members due to my theoretical and educational background. _____ Please sign that you understand.

Please understand that I can refuse to accept you for services if I feel there may be a need for a qualified therapist experienced in court investigation and testimony. I can do neither as I am not qualified.

If you or representative on your behalf, require me to attend a hearing that, in such circumstance, my testimony will be limited to factual testimony only as I am unable to provide professional opinion on any matters. I will be compensated at the rate of \$1500/day or \$750 for a half a day. Please be aware that this will be paid out of pocket and not charged to your health insurance. _____ Please sign that you understand.

Clinical Consultation

Clinical consultation between me and other professionals in this field ensures that I provide the highest quality of service to you and your family. Each client's identity remains completely anonymous, and confidentiality is maintained.

Group, Marriage, or Family Counseling

I will keep confidential (within the limits cited above) anything you disclose to me without your family member's knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge any secret or issue to be detrimental to the therapeutic progress.

When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in treatment.

Within the confines of group/family counseling, it is expected that group and family members will maintain shared information confidential to the therapy setting. However, I cannot guarantee that group or family members will honor this agreement.

Clinical Records

All our communication becomes part of the clinical record. Adult client records are disposed of 10 years after termination of the counseling relationship. Records of minor clients are disposed of 10 years after the client's 18th birthday.

You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In

such a case, I will provide the records to an appropriate and legitimate mental health profession of your choice. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records only with signed authorization from all adults (or all those who legally can authorize such a release). If copies are requested from your file for any reason, there will be a \$25 copying charge that will be paid by you prior to releasing records.

In case of my death or inability to perform my duties, I have assigned responsible individuals to contact my clients about my absence, help refer you to services as needed, and to close files, store them appropriately for the required time, and to dismantle my office as predetermined by my professional will. They are bound by the same confidentiality standards as I would be in the performance of their duties.

Protected Health Information

When I assess, diagnose, treat, or refer you, I will be collecting what the Federal Law (HIPPA) calls Protected Health Information (PHI) about you. I need this information to decide what treatment is best for you and to provide that treatment.

By signing this form, you are agreeing to let me and the staff here to use your information here and share it with others. **I will obtain your written or verbal consent before sharing information with others except for the purposes of billing your insurance or collecting a fee. Consents to release information are typically valid from one year of the date of signature.**

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent), and I will comply with your wishes about using or sharing your information from that time on. Understand though, I may already have used or shared some of your information and cannot change that fact.

I have read, understand, and accept to be bound by the conditions to therapy and the limitations regarding the sharing of counselling records and I expressly agree that I will not ask or seek to compel my therapist's attendance at any judicial or quasi-judicial proceeding of any kind. Further, I understand that Denise Caldwell, LCSW, is solely responsible for my treatment at this office.

Printed Name of Client

Date

Signature of Client

Signature of Clinician

Received Informed Consent Document: Yes _____ No _____

Received Notice of Private Practices: _____ initials

Communication preference(s): Please initial all that apply-

_____ Texting for appointments only

_____ Cell phone message

_____ Landline message