"Strengthening the Families of Southern Utah"
377 E. Riverside Dr. Bldg. B St. George, Utah 84790
(435) 862-8273
www.therapyassociates.net

General Mental Health Psychotherapy Services

Policy/Procedure and Informed Consent

Thank you for choosing counseling services through *Therapy Associates*. Our goal is to provide your family with a range of cost-effective and beneficial counseling services. We want to make this experience as convenient and helpful as possible for you.
Most families that come to counseling for the first time are a little uncertain about what they will be doing, what is expected of them and what the rights and responsibilities of both the therapist and client actually are. This information is being provided to you to help you understand the services and to answer some of the questions that you may have.

OFFICE HOURS. Our office is open Monday through Friday. If you are not able to make an appointment, please call us at (435) 862-8273 or email our receptionist at info@therapyassociates.net.

MESSAGES. If you do not reach our receptionist live, our confidential voicemail is always available to you at (435) 862-8273. You can also email us at info@therapyassociates.net. We will make every effort to make sure that your message will be responded to as soon as possible. If you need to contact us between sessions, you can either call or email us and we will get back with you as soon as we can. Our office manager in the reception area can take messages and can assist you in scheduling future appointments.

APPOINTMENTS. It is recommended that you arrive to your appointments a few minutes early. Counseling sessions are generally 45-50 minutes. Appointments end promptly at the agreed time, even if you arrive late, so we can prepare for the next appointment. We will arrange appointments at your convenience and try to accommodate your schedule as much as possible. We understand that changes are sometimes necessary and are willing to reschedule the appointment. **We do require a 24 hour cancellation notice or you will be charged a $25 missed appointment fee.**

TREATMENT. You are encouraged to obtain and gain knowledge of the therapy process, goals and possible side effects of therapy. We use a variety of traditionally recognized counseling

techniques including cognitive-behavioral, solution-oriented, psychodynamic, psycho-educational and family systems models. Counseling can be very beneficial, and at the same time there are some risks. Risks may include experiencing unwanted or uncomfortable feelings such as anger, sadness, anxiety or guilt which often occur while remembering or talking about unpleasant experiences or events. These feelings are normal and natural and are an important part of the therapy experience. Therapy will give you and your family the chance to talk about topics that are often times difficult and uncomfortable to discuss.

While in therapy, some people make important decisions including changes in relationships, lifestyles and new commitments. It is important to understand that the improvement you are seeking for yourself and/or your child/family is not something that simply occurs as a result of a weekly session with a therapist. This type of life improvement requires an investment on your part and the part of your child/family both in the therapy office with honesty and openness and outside of the therapy office as well. There is no guarantee that therapy will result in positive or desired results. You can terminate therapy at any time you wish.

CONFIDENTIALITY. Information shared with us is protected by professional ethics and state and federal law and will not be disclosed to anyone without your written permission except as identified herein. On certain occasions, it is our responsibility to discuss certain aspects of treatment with other professionals in the *Therapy Associates* practice in order to take advantage of special training or experience they may have. The confidentiality of these consultations, like the confidentiality of your disclosures is protected by both ethics and law and you will be made aware before a consultation of this nature occurs.

The only exceptions to confidentiality are: (1) where there is a danger of actual physical harm to yourself or someone else; (2) when physical or sexual abuse or neglect of a specific minor child or elderly person becomes known or is suspected; (3) in legal cases, your clinical records or we may be subpoenaed by the Court; (4) if you are covered by insurance, information about diagnosis and treatment may be given to the insurance company.

If you have concerns about confidentiality, please discuss with us the degree to which your confidentiality will or will not be protected, and what steps we might take to preserve your privacy.

YOUTH UNDER THE AGE OF 18. If you are requesting services as a parent or guardian on behalf of a minor, the same general practice applies with regard to confidentiality as outlined above. It is important that your dependent have trust in confidentiality in us. However as a parent and guardian you have the right and responsibility to question and understand the nature of the therapeutic activities and progress of your dependent. We must use clinical discretion as to what is appropriate disclosure. In general, specific information will be released with the dependent's consent, but we will discuss the minor's progress as part of your participation in treatment and include you as a parent/guardian in the treatment process.
It is a balancing act to maintain confidentiality with your child, but at the same time keep you posted on your child's progress in therapy. We want to have regular communication with you as the parent. Please involve yourself in the treatment process. We will likely recommend that you

participate in family therapy sessions with your child in addition to individual therapy sessions.

SCOPE OF PRACTICE. It is beyond our education and training to prescribe medication or to give legal advice. We are licensed by the State of Utah to provide mental health assessment and mental health psychotherapy. We do not accept clients that we can't help. If we assess that our services will not benefit you or your family, then we are happy to give you referrals to other professionals that can help.

LITIGATION LIMITATION. Your participation in therapy services may involve making disclosures that are sensitive and confidential in nature. We would like to respect your confidentiality and not be placed in a position to be forced to disclose confidential information. It is agreed that should legal proceedings such as divorce, child custody disputes, etc. occur, that neither you nor your attorney or any other person will call on us to testify or appear in court.

FEES. Our fees are set in accordance with usual and customary fees. They cover time for other activities in your behalf such as research, record keeping and preparation. We want to be able to provide services to families from all income levels. Fees for services are:

Service	Fee
Initial Assessment	$110
Individual/Family Therapy	$90
Group Therapy	$30

Our fees are among the most affordable in all of Southern Utah. We encourage you to call around and compare. You are encouraged to discuss your fees at any time. If we believe that either you or your child could benefit from group therapy, we will discuss it and we will provide you with dates and times of group therapy sessions. Payment is expected at the beginning of each session and will be paid at the reception window. You can pay by cash, check or credit card. If the receptionist is not in, then you will pay your therapist directly. Therapy Associates requires full payment at the time of service.

INSURANCE COVERAGE

For clients that have insurance coverage, full payment is still required at the time of service. In most cases, Therapy Associates will not bill your insurance company, but will provide you with the necessary information to bill your insurance company. **If Therapy Associates bills your insurance company, and coverage is denied, then full payment of the service is your responsibility.**

While using your health insurance to cover the cost of therapy may initially seem like a good idea, we encourage you to pay out of pocket for therapy services for two very important reasons:

1. Paying out of pocket allows you to be in complete control of the sensitive information discussed in your therapy. Many insurance companies require that detailed, sensitive

information be provided about the issues being treated in the therapy before approving coverage. This can be an uncomfortable situation for families concerned about complete confidentiality. In addition, once we provide your insurance company with this sensitive information, we have no way of assuring what they do with it.

2. Paying out of pocket assures that you receive the treatment that you and your family need. Many insurance companies limit the number of sessions that are available to the family and tend to look for the "shortest" and "quickest" way to cover a problem, which in many cases is inadequate in truly helping families get the help they need. Sometimes coverage can be even as few as one or two sessions. Unfortunately, when insurance companies make important decisions about treatment instead of the therapist, families do not receive the help they really need.

We know that quality therapy services can be expensive, and for that reason, we strive to keep our fees affordable. You will find that our fees are among the most affordable in the Southern Utah area.

Therapy Associates

377 E. Riverside Dr. Bldg B. St. George, UT 84790 Phone: 435.862.8273 Fax 435.275-4256 www.therapyassociates.net

Informed Consent Agreement

I have read and understand all of the above *Policy and Informed Consent* and agree to the conditions and confidentiality limits explained therein. I agree to be fully responsible for payment for counseling services. I agree to participate in the counseling plan with the therapist as agreed.

_____ _____

SIGNATURE Of Client (Or Guardian if client is a minor) Date

_____ _____

PRINTED NAME of Client (Or guardian if client is a minor) Date

Therapy Associates

Client Information

Name:
Date of Birth:
Address:
city state zipcode
Home Phone: (____) _____-_____
Cell Phone: (____) _____-_____
Marital Status:
Employment Status:
Email:

Parent/Guardian *(If client is under 18)*

Name:
Date of Birth:
Address:
city state zipcode
Home Phone: (____) _____-_____
Cell Phone: (____) _____-_____
Work Phone: (____) _____-_____
Marital Status:
Employment Status:
Email:

Would you like to receive text or email appointment reminders? Text ☐ Email☐ Both☐

Person Responsible for Billing

Name:
Relationship to Client:
Phone: (____) _____-_____
Address:
city state zipcode
How did you hear about Therapy Associates?

Insurance Information

Policy Holders Name:
Relationship to Client:
Policy Holders Date of Birth:
Policy Holders Address:
city state zipcode
Policy Holders Phone: (____) _____-_____
Name of Insurance:
Insured's ID Number:
Insured's Police Group:
Insured's Plan Name:
Insurance Phone Number: (____) _____-_____