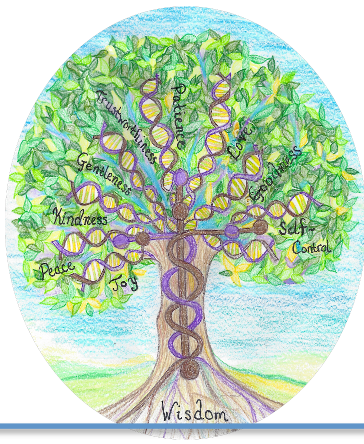


Abundant Living
Health Services

Serving Northern Colorado
(970) 699-6470
www.abundtantlivinghealthservices.com

CONSENT TO TREATMENT

Patient Name: ____________________________ **DOB:** ___________________________________

Welcome to *Abundant Living Health Services!* We are pleased that you are here and desire that you have a positive experience here. This document lays the foundation as it provides important information about our professional and business policies. Please read it carefully and ask any questions you might have at your first appointment. Your signature at the end of this document will represent an agreement between us.

PSYCHOLOGICAL SERVICES
I consent to treatment for myself, or for my child/dependent. I understand that psychotherapy is not easily described in that it varies depending on the personalities of the psychologist and the patient, and what I bring forward. There are many methods that a psychologist may use to support the attainment of my health goals. Psychotherapy differs from an appointment with a medical doctor in that it is most successful when I take an active role both during our session and at home.

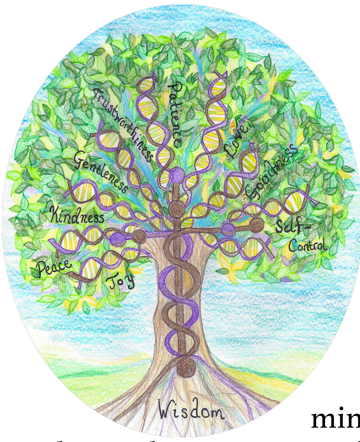
I understand that psychotherapy can have benefits and risks. Therapy often involves discussing difficult aspects of my life and I may experience uncomfortable feelings such as sadness, anger, loneliness, guilt, frustration, and helplessness. Psychotherapy is also shown to have benefits such as reductions in feelings of distress, solutions to specific problems, healthier relationships, and healthier lifestyle choices. There are no guarantees of what I will experience.

Treatment at *Abundant Living* is collaborative and goodness of fit is imperative to positive outcomes. Therapy involves a significant commitment of time, money, and energy, so we want to make sure that we are a good fit. Therefore, the first few sessions will involve an evaluation of needs and treatment planning so we can determine goodness of fit. If you have any questions or concerns at anytime, please bring them forward so that we may discuss them when they arise. If you feel that we are not a good fit, we are happy to facilitate a referral to another mental health professional for a second opinion.

APPOINTMENTS/SESSIONS
Our first session will be 60 minutes during which time an initial evaluation will be conducted. The evaluation may last for 2 or 3 sessions. During this time, you and your therapist will decide if this is a good fit to meet your treatment goals. If you choose to continue in psychotherapy, we will initially schedule weekly sessions that last between 45 minutes or 60 minutes. As therapy progresses we will communicate about frequency and duration of treatment.

PROFESSIONAL FEES
The intake appointment is 60 minutes and the fee is $150. Subsequent sessions are $130 for a 45 to 50 minute session and $140 for a 55 to 60 minute session.

Fees for testing/assessment is $140 per hour (60 minutes) to include face-to-face time, interpretation of tests and report writing.



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Other services including telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals that I have authorized, preparation of records/treatment summaries, and writing letters may be completed for an agreed upon fee.

I understand that should I become involved in legal proceedings that require your participation, I will be expected to pay for professional time at a rate of $250 per hour due to the difficulty of legal involvement. This will include time for preparation, travel time, and attendance at any legal proceeding.

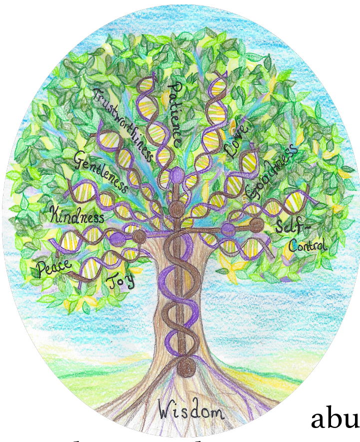
BILLING AND PAYMENT
I understand that payment is due at the beginning of each session unless we agree otherwise. Payment can be made in cash or by checks payable to ***Abundant Living Health Services (ALHS)***.
If my account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, *ALHS* has the option of hiring a collection agency or going through small claims court to obtain payment.

INSURANCE REIMBURSEMENT
I understand that I may submit a Superbill provided by *ALHS* to my insurance company for reimbursement. I recognize that this Superbill will include PHI about me including dates of service, a treatment code (CPT) and a diagnosis. This information will become part of the insurance company files and will likely be stored in a computer.

CONTACT
I understand that *ALHS* clinicians are available by email and telephone. I understand that my clinician will not answer the phone while with a patient. I am free to leave a voicemail and my clinician will make every effort to return my call the day I make it unless it is a weekend or holiday. I understand that if it is an **emergency**, I will contact the nearest emergency room or I will **call 911**. When my clinician is unavailable for an extended period of time we will discuss alternative care or contacts if necessary.

PROFESSIONAL RECORDS
I understand that the law and standards of the profession require *ALHS* to keep treatment records. I am entitled to receive a copy of my records or a summary should I desire. Because these are professional records, I understand that they can be misinterpreted and/or upsetting to untrained readers. If I wish to see my records, it is recommended that I review them with my clinical so that we can discuss the contents. I understand that I will be charged an appropriate fee for time spent in respond to such a request. I also understand that my records will be kept for 7 years after treatment has ended or if I am a minor, they will be kept for 7 years after I turn 18.

CONFIDENTIALITY
I understand that in general, the law protects the privacy of communication between a patient and psychologist and that information can be release only with my written permission. I acknowledge that there are a few exceptions.



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Psychologists are required by law to report reasonable suspicion of child abuse and elder abuse. Additionally, if I threaten serious bodily harm to another, my clinician is required to take protective action such as notifying the potential victim, contacting the police or seeking hospitalization. If I threaten to harm myself, my clinician and I will generate a plan to keep me safe which may include contacting family members to help provide protection or seeking hospitalization. These situations rarely arise and when they do my clinician will make every effort to fully discuss it with me before taking any action.

In most legal proceedings, I may prevent *ALHS* from providing any information about my treatment. I understand that in some proceedings involving child custody or those in which my emotional condition is an important issue, a judge may order testimony from my clinician.

CONSULTATION AND COORDINATION
As *Abundant Living Health Services* believes that a holistic approach is most beneficial to support abundant living, my clinician (with my consent) will provide summaries and/or coordinate care via verbal communication with other health professionals involved in my care.

It may also be helpful at some point for my clinician to consult with another professional about our work together. If so, my clinician will make every effort to avoid revealing my identity. Additionally, the consultant is legally bound to keep the informational confidential.

If there are other concerns that arise for me, I agree to speak directly to my clinician and/or the owner, Alicia Young, Ph.D. about them directly. I understand that because the laws governing confidentiality are quite complex, legal advice may be needed as Dr. Young is not an attorney.

MINORS
I understand that for clients who are minors, the law may provide parents the right to examine treatment records. As trust is a crucial element in successful psychotherapy, it is *ALHS* policy to provide parents with general information about our work together so that parents can support our work at home. However, if my clinician believes that there is a high risk that I will harm myself or someone else, my parents will be notified. Prior to giving my parents any specific information, we will discuss it together.

I have read this document and signify with my signature that I understand and agree to the above information.

____ __________________________

Patient/Guardian Signature **Date**