Practice Policies & Consent to Treatment

Ashton N. Heckmann, MS, NCC
Psychotherapist

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount of your appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

The standard fee for each session is $75.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by cash or credit card.

Also, I am not paneled with any insurance carriers and therefore do not file insurance claims. However, you may pay with and Health Savings Account (HSA) card and receive an itemized receipt from me to turn into your insurance provider. If your insurance provider or another third party will be covering the cost of your counseling, then you need to make arrangements with them to reimburse you directly. You are responsible

for obtaining and completing any appropriate paperwork and submitting it to the insurance company. I am willing to fill out any part of the form that is necessary. (This may include additional fees and does not insure that they will reimburse you.)

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are as follows. I will keep the information you share with me in session confidential, unless I you're your written consent to disclose certain information. There are a few exceptions to this rule that are important for you to understand before you share personal information with me in sessions.

In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. These exceptions involve the disclosure of serious harm or death to yourself or someone else and I believe you have the intent and ability to carry out the threat. This also includes current or past abuse of a child or elderly person. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy to request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message with the front office staff and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. I will make every attempt to inform you in advance of planned absences. If you feel unable to keep yourself safe, 1) contact Lakeside Behavioral Health Hospital 2) go to your local hospital Emergency Room, or 3) call 911.

LIMITATIONS TO MY PRACTICE

My role as a therapist is not to gather information for litigation matters or to make judgements related to court decisions. I will not testify in a future divorce or custody action case. I can refer you to other therapists

who have experience with the court systems. It is my policy to have no court involvement because that could harm our therapeutic relationship and your ability to achieve your goals.

SUPERVISION

I am a Pre-Licensed, Nationally Certified Counselor. I am currently under supervision, for my license, by Keith B. Fussell, LMFT; LPC-MHSP.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Client Signature: _____ Date: _____

Printed Name: _____

Adolescent therapy client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with therapy, you can ask your therapist at any time.

Minor's Signature _____ Date_____

Parent/Guardian:

Signing below indicates that I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her supervisor.

Parent Signature _____ Date_____

Parent Signature _____ Date_____

Therapist Signature _____ Date_____