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Erin Bougher, MA
Lauren Erickson, MS

Behavioral Health Services

www.mybehavioralhealth.com

Consent Form

Clinician: _____

Patient Name:_____(PRINT) **DOB:_____**

Consent to Treatment

I, _____ , do hereby give consent to treatment on behalf of my child as listed above.

Parent / Legal guardian (Print)

I authorize Behavioral Health to: (PLEASE CIRCLE)

* Release information to the school for collaboration of services

Yes No

* Release information to the PCP or any other Mental Health provider for collaboration of services

Yes No

Outside Mental Health Services

Most mental health services can not be combined with other mental health services such as (Out patient therapy, in school therapy, family base, partial hospitalization, etc) Insurances consider this to be a duplication of services. Please inform staff or your child's therapist if your child is receiving other mental health services outside of us.

Please be advised that our office does not prescribe medications, we provide psychotherapy services only
You may visit our website at www.Mybehavioralhealth.com for a listing of all services offered.

No Show Policy

No showing for 3 appointments in a one-year period will result in being transferred to another provider or out of Behavioral Health at the discretion of the provider. (This includes every member of the family)

All appointments must be cancelled at least 24 hours prior to the time of the scheduled appointment, or it will be counted as a **NO SHOW**.

Showing late for an appointment may result in having to be rescheduled and would therefore be considered a **NO SHOW**. We ask all patients to arrive 15 minutes prior to the scheduled appointment.

Financial Responsibility

I understand and agree to the following terms related to payment for services provided by Behavioral Health

1. Not all of our providers participate with all insurances or counties. I agree to inform Behavioral Health as soon as insurance would term, begin, change, be added, or if I move counties in a timely manner. I understand that if I fail to provide all insurance information , updates, and or changes, that I will be held solely responsible for all expenses.

2. I authorize PCS Behavioral Health to bill my / my child's insurance carrier(s) and request such payments to be made directly to PCS. I authorize PCS to act on my / my child's behalf and as my / my child's representative to request reconsideration (internal and / or external review process) by my / my child's managed care plan or utilization review entity for coverage or grievance review.

3. Payment for services rendered must be received in a timely manner or the account will be subject to collections and the patient may be dismissed from the practice for non-compliance.

4. Copays are due at the time of service as per your agreement with your insurance company. Receipts will be provided should you need reimbursed from an outside source or another party.

5.In the event of a court order stating that medical expenses are the responsibility of another party or split between two or more parties, the court order must be presented to our office. All arrangements must be made with our billing department prior to the appointments to ensure that payment arrangements are handled correctly.

_____ _____ _____

Print **Signature** **Date**

CONSENT FOR PSYCHOTHERAPY

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights that are important for you to know as well as certain limitations to those rights. This document contains important information about the professional services and business policies of PCS Behavioral Health.

Unlicensed Clinicians: Erin Shutty, MS, Erin Bougher, MA, Lauren Erickson, MA, Jessica Berkey MSW

Sophia Walder – Hoge, MA are under the supervision of Joshua Watt, PsyD and Ian Goncher, PsyD.

Any questions or concerns can be directed to Dr. Watt and Dr. Goncher at any time by calling **814-266-8840**

I. Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone you wish to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

Communication via email is rarely advised or recommended. However, if you elect to communicate with me by email at some point in our work together, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.

If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child Protective Services within 48 hours and Adult Protective Services immediately.

If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I would call the crisis team.

If you tell me of the behavior of another named health or mental health care provider that informs me that this person has either a. engaged in sexual contact with a patient, including yourself or b. is impaired from practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this to their licensing board at the PA Dept. of Health. I would inform you before taking this step. If you are my client and a health care provider, however, your confidentiality remains protected under the law from this kind of reporting.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in marital/couples therapy with me.

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

II. Record-keeping

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

If you are under fourteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

III. Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the DSM-V; PCS has a copy of this manual on site. If there are questions about you or your child's diagnosis, I will be glad assist you in learning more about what it says about the diagnosis.

IV. Other Rights, Risks and Benefits of Therapy

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward.

There are many different methods I may use to deal with the problems that you hope to address.

Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy or change therapists at any time.

If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are in my judgment not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you do violence to, threaten, verbally or physically, or harass myself, the office, any of my staff or myself/staff family members, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

I am away from the office several times in the year for extended vacations or to attend professional meetings. If I am not taking and responding to phone messages during those times I will have someone cover my practice. I will make every effort to tell you in advance of any lengthy absences, and give you the name and phone number of the therapist who will be covering my clients during my absence. Due to my work schedule I am rarely available for between session phone calls during normal business hours. If you are experiencing an emergency when I am out of town, or outside of my regular office hours (usually after 5 pm weekdays or over the weekend), please call Crisis Intervention Services at 1-877-268-9463, which are available 24 hours a day, 7 days per week. If you believe that you cannot keep yourself safe, please call 911, or go to the nearest hospital emergency room for assistance.

V. Managed Mental Health Care

If your therapy is being paid for in full or in part by a managed care firm, there are usually further limitations to your rights as a client imposed by the contract of the managed care firm. These may include their decision to limit the number of sessions available to you, to decide the time period within which you must complete your therapy with me, or to require you to use medication if their reviewing professional deems it appropriate. They may also decide that you must see another therapist in their network rather than me, if I am not on their list. Such firms also usually require some sort of detailed reports of your progress in therapy, and on occasion, copies of your case file, on a regular basis. I do not have control over any aspect of their rules. However, I will do all that I can to maximize the benefits you receive by filing necessary forms and gaining required authorizations for treatment, and assist you in advocating with the managed care company as needed.

VI. Divorce, Custody or Legal Issues

As a mental health treatment practice our primary focus, responsibility and goal is the treatment and wellbeing of our identified patients. In the case of a child as the primary patient it is essential that parents and legal guardians are not in conflict and are in fact in agreement as to decision to treat, the treatment goals, appointment times and the need to maintain patient confidentiality. The therapeutic process is a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible. Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means, that you each agree as a condition of us treating your child that:

You shall treat anything that is said in any individual or group therapy session as strictly confidential

Our role is limited to providing treatment and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child

You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child

If multiple parents or guardians desire to obtain treatment information and/or testimony from any one of our clinicians relating to your child in any legal proceeding you shall each consent to the disclosure by executing one or more authorization forms we send to you and you will each share in the cost of producing such records and/or written or live testimony at our established copying charges and/or hourly rates for our clinician's time.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.

Your signature below indicates that you have read the information in this agreement and agree to abide by its terms during our professional relationship. More specifically, your signature indicates that:

1. You have been informed of and understand the nature of services to be provided and both the expectations of the therapist and the therapy client.
2. You have been informed of the limits of confidentiality.
3. You understand and agree to my payment and cancellation policies.
4. You accept full responsibility for all fees incurred in receiving my professional services.

_____	_____	_____
Print	**Signature**	**Date**

You the right at any time to REVOKE consent for treatment. Please contact our office with any questions or concerns that you may have at 814-266-8840.