INFORMED CONSENT FOR GROUP THERAPY SERVICES

_____ (*therapist/practice name*) is committed to providing quality individualized services, and this consent addresses important information about service procedures and client rights in a group setting. A mental health provider will explain this information to you during your initial visit. It is important for you to understand the policy and treatment information described below prior to the start of your group therapy sessions.

PSYCHOLOGICAL SERVICES

Group therapy can help individuals develop skills to enhance interpersonal relationships, behavior, emotional and mental health, coping skills, and self awareness. It is designed so group members can communicate and share experiences, allowing for the development of trust. The group therapy process might stimulate some uncomfortable feelings and emotions. Participation does not guarantee problem resolution. As with all medical and psychological treatments, there are benefits and risks. If you have any questions, please ask your therapist any time during the therapy process.

APPOINTMENTS

Group sessions run from _____ (*date*) to _____ (*date*) on _____

(*day of week*) at _____ (*time*) for _____ minutes.

Due to the importance of each member in the group dynamic, it is important for each participant to commit to the time periods identified above. If you will have difficulty attending all sessions or need a modified schedule, please talk to the therapist. Please be punctual. Each group has an allotted scheduled time. Tardiness may disrupt the start of the session, which will still conclude at the originally scheduled time.

PROFESSIONAL FEES

_____ (*name of therapist/practice*) charges $_____ fee for each

group session. Exceptions to standard charges may be discussed and agreed upon by

_____ (*name of client*) and _____

(*name of therapist/practice*).

_____ (*name of therapist/practice*) does not accept health

insurance/accepts the following health insurance: _____.

It is important for you to be aware that your health insurance may not cover the cost of services. You are responsible for knowing your health insurance plan. The therapist/practice's billing department will assist you if necessary. If your health insurance policy covers the costs of mental health treatments and you choose to use your health insurance policy, the insurance group may require your therapist/the practice to share your medical records and diagnoses for their records. Some health insurance companies require authorization for treatment. If authorization is denied, the patient is responsible for fees accrued.

Under the circumstances that _____ (*name of therapist/practice*) does not accept your health insurance, your therapist/the practice will supply you a receipt of payment for services. You can submit this receipt to your insurance company for reimbursement.

Payment must be made by **check**, **cash**, and/or **credit**. Your fee or co-pay is due at the time services are provided. The client is responsible for all fees. This includes any fees denied by insurance providers. Fees must be paid within 30 days after the date the claim is denied.

Returned checks will result in an additional service fee of $_____.

CONFIDENTIALITY

_____ (*name of therapist/practice*) is committed to following the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and client rights regarding the use and disclosure of Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. All information, discussions, and documents are confidential and privileged information for all clients. Under federal law, disclosure of information regarding services provided and information about a client requires written consent to release to alternate or third parties.

The following are exceptions to the rules of confidentiality:

1. When there is imminent danger to the client or another person.
2. Under circumstances of suspected child, elder, or dependent adult abuse or neglect.
3. When disclosure must be made to medical professionals in the case of a medical emergency.
4. When the mental health professional is compelled by law to disclose client records.

_____ (*name of therapist/practice*) is a professional setting of mental health professionals. Your therapist might consult with colleagues/mental health professionals about your case. Your name will not be disclosed and your identity will be kept disguised. Consults will only be used for the betterment of your treatment.

The therapist will adhere to the ethical and legal requirements of confidentiality. Each member of the group is required to sign a confidentiality agreement; however, the therapist cannot ensure that you or members of the group will maintain the same level of confidentiality about your group interactions.

PROFESSIONAL RECORDS

Service providers are required, by law, to keep medical records of psychological services provided. All records will be secured in a locked location following Health Insurance Portability and Accountability Act (HIPAA) standards. Records include, but are not limited to, documentation of attendance; purpose of treatment; any medical, social, and treatment history; evaluations and diagnosis; anecdotal notes of topics and discussions; copies of legal forms and consents; documents and copies of any forms or information shared with other professionals; and information provided by other professionals.

_____ (*name of therapist/practice*) utilizes health information technology (Health IT), which involves the storage and exchange of health information in an electronic environment. We are committed to upholding privacy and security standards for the protection of electronic health information standardized by HIPAA. The Security Rule requires covered entities to maintain reasonable and appropriate administrative, technical, and physical safeguards for

protecting electronic protected health information (e-PHI). The therapist/practice is committed to ensuring the confidentiality and integrity of all e-PHI created, received, stored, or transmitted. This includes protecting client information from potential security threats, maintaining privacy disclosure statements, and using only authorized technical devices with security systems.

Patients have a right to copies of their files and to access copies of their files for other health care providers with a written request. These are professional records and there is a possibility they may be misinterpreted and/or upsetting to untrained readers. Your therapist/the practice recommends you review the documents with your therapist or have them forwarded to another mental health professional for initial viewing.

It is the right of the mental health professional to refuse access to your files if access to the documents may prove to be harmful to you. If your therapist/the practice refuses your request for access to your records, your rights will be discussed with you.

CLINIC HOURS

_____ (*name of therapist/practice*)'s regular office hours are from:

_____ (*time*) to _____ (*time*), _____ (*day*) through _____ (*day*). If you would like to make additional appointments, please call the clinic during clinic hours. Appointments during off-clinic hours may be arranged with agreement from your therapist.

This clinic does not provide emergency services. Please call _____ if you would like to schedule an appointment as soon as possible. **If you have an immediate emergency, call 911 or go to the nearest emergency room.**

PATIENT RIGHTS

You have the right to considerate, safe, and respectful care, in the absence of discrimination regarding race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy, therapist training, and therapist experience. You have the right to communicate your therapeutic needs if you feel dissatisfied or feel like any of the above-mentioned rights have been violated in any manner. You have the right to request a change in service providers. In this case, your current service provider will assist in providing the necessary information to the new service provider with written consent by the patient.

TERMINATION OF TREATMENT

The therapist has the right to terminate treatment at any time due to lack of payment, prescriptions not filled, or a development occurring outside the scope of the therapist's area of competence. In the case of termination, the therapist will support a transition to provider of continued care as needed.

Therapeutic counseling can result in changes in relationships, emotional state, and behavioral patterns. There are circumstances that result in a lack of improvement. Under circumstances of extreme discomfort and emotional pain, the client has the right to terminate or discontinue services.

CONSENT TO PSYCHOTHERAPY

I voluntarily agree to receive group therapy with _____ (*name of therapist/practice*). I understand I have the right to terminate such care and services that I receive from the undersigned therapist at any time.

My signature affirms that I have read and communicated the above information to my mental health service provider. The information presented is understood and enables me to make an educated, voluntary consent to treatment.

Group Name: _____

Meeting Times: _____

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

_____

Printed Name of Therapist

_____ _____

Signature of Therapist Date