Chantal Cohen Therapy, LLC

Chantal Cohen, MA, LMFT
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Privacy of Information Shared in Therapy: Rights and Policies

Informed Consent

Thank you for choosing Chantal Cohen, MA, LMFT for therapy. I realize that starting therapy is a major decision and you may have many questions. This document is intended to inform you of policies, state and federal laws, and your rights. If you have any other questions or concerns, please ask and I will ensure you have the information needed.

Please read the document entirely. Once you have a full understanding of the information given here, please initial each section and sign on the last past page. Your initials will indicate your understanding and agreement for your child and/or family to participate in services.

_____COUNSELING SERVICES

Mental health therapy is not easily described in general statements. It varies depending on the personality and the particular issues brought forward. There are many different methods I may use to deal with the concerns that you hope to address. Some of the most frequent therapeutic practices I employ include: Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), Internal Family Systems (IFS), Satir Therapeutic Interventions, Narrative Therapy, Motivational Interviewing, Solution Focused, Client Centered Therapy, as well as Expressive Play Therapy, Art Therapy techniques, and Family Systems Therapy.

Mental health therapy is not like a medical doctor visit. Instead, it calls for collaboration between us and 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 as well as make a commitment to attend sessions as scheduled. Mental health therapy can have benefits and risks. Therapy can often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Our first session will involve an evaluation of you and/or your child's needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and an outline of 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. Should the sessions not meet your needs in any way, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

_____MEETINGS and CANCELLATION POLICY

Our first session is for initial evaluation to obtain a history and answer questions you may have about therapy. During this time of 90 minutes we can both decide if I am the best person to provide the services you need in order to meet your goals. If we start therapy, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Therapy sessions are only made by appointment. Because your time is reserved for only you, it is necessary to provide 24 hour for cancellations as there will be others who may be able to fill the slot of time. Appointments without 24 cancellation (no show or late

cancel) will be charged the full fee of the missed session, which is not covered by insurance. Exceptions other than illness or family emergencies must be agreed upon in advance.

_____CONTACTING ME & EMERGENCIES

I am often not immediately available by telephone as I will be meeting with others for assessments or therapy. However I check my voice mail and email throughout the week and will make every effort to return your call within 72 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or contact Emergency Services at any local emergency room, call 9-1-1 or call the mental health crisis line at (907) 563-3200.
If I will be unavailable for an extended time, I will provide you advanced notice.

_____ELECTRONIC COMMUICATION

EMAILS, TEXTING, COMPUTERS AND FAXES: It is very important to be aware that computers and unencrypted email, texts, and e-fax communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts and e-faxes that go through them. It is always a possibility that e-faxes, texts, and email can be sent erroneously to the wrong address and computers. Phone messages at Ms. Cohen's number are confidential and password protected. If you communicate confidential or private information via unencrypted email, texts or e-fax or via phone messages, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and will honor your desire to communicate on such matters. Please do not use texts, email, voice mail, or faxes for emergencies. Please limit these types of communication to non-confidential information.

Please indicate below which method of communication you authorize

_____ **YES or NO** You may leave a message on my answering machine

_____ **YES or NO** You may email me information which may or may not be intercepted

_____ **YES or NO** You may contact me and leave me a message or text on my cell phone

In regards to communication via E-fax or Fax. Please note that my Fax No.: (907) 202-5452 is through Faxage and is HIPAA Compliant. My Fax Account is password protected and is encrypted by Faxage. Confidential information may be sent via the fax number referenced above .

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_____PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records if a records request is made in writing. At times it may be necessary to deny records request due to real or potential safety concerns. Professional records 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; or with your signed consent I can send them to another mental health professional who is working with you. Clients should make all

records requests in writing and will be charged an appropriate fee for any professional time spent responding to information requests.

For clients under eighteen years of age, the law provides parents the right to examine minor's treatment records. It is my policy to request an agreement from parents that they agree to give up access to minor's record to protect the therapeutic relationship. I will provide parents only with general information about our work together or agreed upon differently with the minor, unless there is a high risk of serious harm to oneself or another. In this case, I will notify parents of my concern. Before giving parents any information, I will discuss the matter with the minor, if possible, and do my best to handle any objections the minor may have with what I am prepared to discuss. It is often beneficial to include one or more family members in treatment sessions. A schedule for such sessions may be determined following the initial evaluation session or be set up on an "as needed" basis.

_____COURT EVALUTIONS AND TESTIMONY

Please be aware that I provide therapy and that I do not conduct evaluations for the purposes of forensic investigations, custody disputes, or usually testify in court. However, if subpoenaed, I may be required to testify in court, which does not require your consent. If you are in need of this particular service, it is recommended that you retain an independent evaluator who specializes in that type of work. Clients will be charged an appropriate fee for any professional time spent responding to this request, something insurance does not cover.

_____BILLING AND COLLECTIONS

If you elect to have Ms. Cohen bill insurance on behalf of the client, please inform and present with your insurance card. Each insurance company and plan is different and may vary on coverage. It is recommended to call your insurance company before session to see what is covered. Your co-pay is due at the time of service. If your insurance has an unmet deductible, or denies payment based on lack of medical necessity then you will be responsible for the full session fee. If your credit card on file is denied to pay for the co-pay or session amount, your bill and necessary information will be sent to a collections agency to collect payment. It is highly recommended to keep your credit card up to date to avoid collections.

_____CONFIDENTIALITY

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with written permission. However, there are a few exceptions. They are as follows:

- The law requires that I notify others if I judge that a client has made a clear threat of violence to an identifiable victim.
- If I assess the client to be suicidal or unable to take care of her/himself, I may notify proper authorities to arrange for further intervention.
- I am obligated by law to report suspected physical or sexual abuse or severe neglect of children, elderly or the handicapped.
- If subpoenaed by a legitimate court of law.
- When insurance reviewers request information about your therapeutic progress, Chantal Cohen, MA, LMFT will release information only as requested. Ms. Cohen may release your name and information as well for bill collections processing.
- There may be times when I discuss the details of your treatment with a consultant. The consultant is also bound to keep the information confidential.

AGREEMENT

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. I have received and read a copy of the above material (Counseling Services, Meetings and Cancellation Policy, Contacting Me & Emergencies, Electronic Communication, Disclosure Statement, Professional Records, Services for Minors, HIPAA, Court Evaluations & Testimony, Billing & Collections and Confidentiality). I hereby consent to abide by the terms outlined above.

_____

Signature Date

_____

Printed Name

_____

Signature Date

_____

Printed Name

_____

Signature of Therapist Date

- **_____ MY INITIALS VERIFY THAT I RECEIVED A COPY OF: DISCLOSURE STATEMENT**

OR

- **_____ MY INITIALS VERIFY THAT I REFUSED A COPY OF: DISCLOSURE STATEMENT**
-
- **_____ MY INITIALS VERIFY THAT I RECEIVED COPY AND READ: HIPPA DENIED A COPY AND**
- **OR**
- **_____ MY INITIALS VERIFY THAT I READ HIPAA BUY REFUSED A COPY**