**Shawna Fox, MS**
**Phone: 907-929-4009**
**Email: therapy@shawnafox.com**

**Name of Supervisor: Mike Blakey, PsyD**
**Supervisor's Contact: 907-929-4009**

## Informed Consent

You have taken a very positive step by deciding to seek therapy. 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.

As you read this feel free to mark any places which are not clear to you or write in any questions which come to mind, so we can discuss them. Both of us need to be clear as to what your needs are and how I can best serve those needs. This will allow us to work most productively and comfortably together. If our work together uncovers a problem area beyond my expertise, I will help you obtain services from an appropriate specialist.

## Understanding Therapy

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 therapy, 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.

### Benefits and Risks

The outcome of your treatment depends largely on your willingness to engage in the therapeutic process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, sadness, anxiety, etc. 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. 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. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and your repeating patterns, as well as to help you clarify what it is that you want for yourself.

### What to Expect

The first 1-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At

that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will do my best to refer you to another mental health professional for a second opinion.

## Appointments

Appointments will ordinarily be one hour 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.

Please note, 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 co-payment --unless we both agree that you were unable to attend due to circumstances beyond your control.** If it is possible, I will try to find another time to reschedule the 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.

## 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 desk and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters.

Our administrative staff is in the office from 9am-5pm Monday through Thursday (phones are off from 1-2 for lunch) and 9am to 4pm on Fridays to accept all calls. If you are calling after these hours to cancel or change an appointment you must leave a message on the voicemail.

Please see my professional email in the below “Contacting You” section.

## Emergency

**In case of emergency,** please call 911 and ask to speak to the mental health worker on call. Additionally, you may call the 24 hour crisis line at **907-563-3200 or text HOME to 741741** for the 24 hour crisis text line.

## Contacting You

It is my intent to respect your boundaries and autonomy. As a general rule, I do not utilize text as a communication method with clients or engage via social media. However, I do have a professional email we may use for contact outside of session: **therapy@shawnafox.com.** Please note this email is not HIPAA secure, so I ask that you do not send protected health information via email.

After your initial consultation, follow up with you via email a week after to check in and provide any additional resources to you that may be helpful. However, you are always welcome to decline this contact.

If you miss an appointment without calling or stop scheduling without expressing a desire to terminate services, I may reach out to you to check in and to make sure that you are doing okay.

If I do not hear back from you within approximately a month, I will presume that you are not wishing to continue therapy at that time and consider your case closed. Still, you are always welcome to reach out to resume therapy.

**Professional Fees**

The fee for the initial intake is $330 and each subsequent session is $150. If you are self-pay, we are able to offer a 20% discount, making the first session $264 and subsequent sessions $120. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment may be made by cash, check, or card.

**Insurance**

At this time, I am able to bill private insurances: Blue Cross, AETNA, and Moda. As a clinic, we are in network with Blue Cross and AETNA. If you have a Moda plan, you are responsible for making sure the plan has out-of-network mental health benefits. Also, please note, as a master's-level clinician working toward licensure, I am not currently able to bill to Medicare, Medicaid, or Tricare.

**Confidentiality**

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons.

**Limitations of such client held privilege of confidentiality exist and are itemized below:**

1. If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a imminent risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report
to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your identifying data.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

**HIPAA**
HIPAA provides you with several rights with regards to your clinical record and disclosure of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information in your clinical record is disclosed to others; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of the complete HIPAA Guidelines. I am happy to discuss any of these rights with you and/or provide you with a hardcopy per your request.

**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. Because these are professional records, they may be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

**Other Rights**
If you are unhappy with what is happening in therapy, I hope you will discuss this 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, without discrimination as to 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 and about my specific training and experience.

I agree that my signature below indicates that I am aware that I am receiving counseling from a Master's level counselor (someone who has graduated from a Master's program in counseling psychology) who is currently working toward the hours required for professional licensure. I understand that at this time they are not licensed. I have been informed that the counselor is working under the supervision and direction of Mike Blakey, PsyD, and that he can be contacted at 907-929-4009 with concerns or questions in regards to the services rendered.

________________________________________________________________________

Signature Date

________________________________________________________________________

Printed Name

## FINANCIAL AGREEMENT

For services rendered and to be rendered, I will promise to pay Shawna Fox, MS at Greatland Clinical Associates. I understand that the total charges are due when services are rendered.

**I understand that I am financially responsible for missed appointments in which I do not give a 24-hour notice. Notice may be given via phone call to the office or by email at therapy@shawnafox.com. The fee for a missed visit in which 24-hour notice is not given is your copay amount. If you are self-pay, the fee for a missed appointment is $50. This fee will be expected upon arrival of your next visit or charged to the credit card on file, before services are rendered.**

**Please provide us with your credit card information. This card will be charged for your copay amount after services are provided or if less than 24-hour notice is given to cancel an appointment.**

Name as it appears on card: ________________________________________

Card #: ________________________________________________________

Expiration Date: ___________________ CV Code: _____________________

**By signing below, I am agreeing to the terms and conditions of this financial contract.**

_______________________________________________________________________________

Signature Date

_______________________________________________________________________________

Printed Name