# Pediatric Counseling Center

**375 Collins Road NE, Cedar Rapids Iowa 52402**
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## INFORMED CONSENT
## POLICY and PROCEDURES for THERAPY SERVICES

Welcome to Pediatric Counseling Center. This document contains important information about our professional services and business policies. Please read it carefully and ask any questions you have. When you sign this document, it will represent an agreement between us.

### THERAPY SERVICES

The purpose of therapy is to address the needs and concerns for you and your child. The parent's role in therapy is essential. Your role in your child's therapy will vary, depending on the issues presented, family dynamics and the phase of therapy. Your participation could involve: mutual problem solving, understanding your child's diagnosis, learning new behavioral management and parenting strategies and supporting your child's emotional growth and development. You will be involved in developing goals for your child. It is important to know, best progress is made with consistent attendance, parent involvement and active participation.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, behaviors temporarily increasing and conflicts. However, therapy has been shown to have benefits for children who have gone through it. Therapy often leads to improved parent/child relationships, solutions to specific problems and significant decrease in feelings of distress. There are no guarantees on what you and your child will experience. However, we will work with you the best we can to provide a positive therapy experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan to follow. Sessions are typically 45-50 minutes long on a weekly basis. Dependent on need, some sessions may be longer in duration. It is important for you to come on time, so you receive the benefit of a full-length session. If you are late for your appointment, it is likely that your session will be completed at the time it was scheduled to end.

### MISSED APPOINTMENTS

Once an appointment is scheduled, you can cancel for any reason. However, you will be expected to attend unless you provide 24 hours notice of cancelation (unless we both agree that you were unable to attend due to circumstances beyond your control). If you fail to attend a scheduled session or cancel session with less than 24 hours notice, you will receive a charge of $35.00. If this is a continuing pattern, your care may be discontinued at Pediatric Counseling Center.

**Important Note:** If you are more than 20 minutes late without notifying our practice, your appointment will be considered cancelled and you will be charged a no show fee of $35.00.

It is important for you to understand that our schedules are quite full. Thus, you may not always be able to reschedule easily for the same week in which you cancelled or missed an appointment. You may not always be able to secure times for your child for after school appointments. However, we will do the best we can to work with you on any scheduling concerns you may have.

### PROFESSIONAL FEES

Our professional fees vary per the service provided. You can request a list of these charges. In addition to weekly appointments, we may charge for other professional services you may need (e.g., telephone conversations lasting

longer than 15 minutes, attendance at meetings with other professions you have authorized.) Any legal proceedings with your child/family will need to be discussed prior to our participation, and a separate legal service fee contract will need to be discussed and signed.

**BILLING AND PAYMENT**

You will be expected to pay for each session at the time it is held. We require a credit card to be kept on file to cover unpaid charges on your account. Charges to your credit/debit card are processed through Kasa and will appear on your bill as Mental Health Billing.

The parent who brings the child is responsible for payment or co-payment of each session at the time it is held. If the child attends session without parent, payment will need to be sent with the child or know the credit card on file will be charged. Payments can be made by cash or credit/debit card.

**DELINQUENT ACCOUNTS**

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

**INSURANCE REIMBURSEMENT**

For us to set realistic treatment goals and priorities, it is important for you to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. You (not your insurance company) are responsible for full payment of our fees. It is important that you find out exactly what mental health services your insurance policy covers prior to your first appointment. You should carefully read the section in your insurance coverage booklet that describes mental health services. We request that you call your plan administrator prior to your first appointment to verify your benefits and receive your authorization for mental health services. If your policy limits the number of mental health visits within a given year, you are responsible for keeping track of these visits, as oftentimes other providers (i.e., psychiatry visits) are included in this number of sessions. We will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. You should also be aware that insurance companies require your therapist to provide them with a clinical diagnosis. Sometimes therapists must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above.

**CONTACTING US**

We are often not immediately available by telephone. We do not answer our phones while we are with clients or otherwise unavailable. At these times, leave a confidential voice-mail message and we will get back to you as soon as possible. We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering our practice.

If you feel you are unable to keep yourself/child safe:

- Contact a 24-hour Crisis Line:
    - Foundation 2:
- 1-800-332-4224 or 319-362-2174
- foundation2crisischat.org 4
- Crisis Text Line:

  - Text "start" or "go" to 741741
- National Suicide Prevention Lifeline
  - 1-800-273-8255
- Call 911 or go directly to the emergency room.

**PROFESSIONAL RECORDS**

The laws and standards of our profession require that we keep treatment records. Pediatric Counseling Center records are stored with Kasa. Kasa uses a secure and encrypted, HIPPA Compliant Electronic Medical Health Record (EMR).

Recent legal developments indicate that parents do not always have full access to their child's mental health and substance abuse treatment records. To protect your child's need for privacy, it is our policy to not provide parents copies of their child's treatment records. We will provide you with general information about your child's work in therapy. Under the limits of confidentiality, if there is a risk that your child will seriously harm himself/herself, engage in high risk activities, or harm someone else we will inform you. Before giving parents information, we will discuss the matter with the child, if possible, and do our best to handle any objections s/he may have with what we are prepared to discuss.

**CONFIDENTIALITY**

In general, the privacy of all communications between a client and a therapist is protected by law, and we can only release information about our work to others with your written permission. Typically, we will ask you to sign a release to share information with your physician for care coordination. Often other family members are involved with your child's daily life. These may include stepparents, partners, or grandparents. When other adults will be bringing your child for treatment or are involved in supporting treatment, parents will be asked to sign a release of information giving the therapist permission to talk with those individuals about your child.

Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our client. The other professionals are also legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless she feels that it is important to your work together.

If a client threatens to harm himself/herself, your therapist may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a patient communicates an imminent threat of serious physical harm to an identifiable victim, we may be required to disclose information to take protective actions. This is known as Duty to Warn. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If we have reasonable cause to believe that a child has been abused or suspect that a dependent adult has been abused, the law requires that we file a report with the appropriate government agency, usually the Department of Human Services. Suspected child abuse can include, but not limited to: domestic violence, sexual abuse, physical abuse, mental injury, exposure to drugs and neglect. Once such a report is filed, we may be required to provide additional information. The therapist is not responsible for investigating or authenticating any allegations and it is not their role to determine if the reported abuse meets qualifications for reception of an investigation by the Department of Human Services.

As outlined in Iowa Code 237.21 for any child receiving treatment while in foster placement, your therapist is responsible for providing information to the Iowa Foster Care Review Board.

If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

If a client files a complaint or lawsuit against our office, we may disclose relevant information regarding that client to defend our practice.

If a client files a worker's compensation claim, we must, upon appropriate request, provide any information concerning the employee's physical or mental condition relative to the claim.

## GROUNDS FOR TERMINATION

Services are provided at our discretion. We reserve the right to terminate therapy services if either parent behaves inappropriately toward us or our staff, if we are court-ordered to testify (thus causing a dual-role relationship with your child), if there is consistent failure to attend scheduled appointments, and if there is failure to complete payment for services.

## OTHER RIGHTS

If you are unhappy with what is happening in therapy, we hope you will talk with your therapist so that they can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we 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 our therapist's specific training and experience. You have the right to expect that we will not have social or sexual relationships with clients or with former clients.

## INFORMED CONSENT AGREEMENT

It is important that you have read (or had read to you) and reviewed this form carefully so that you understand all of the office procedures and policies regarding Pediatric Counseling Center. Your signature below indicates that:

1. You have had sufficient opportunity to read and understand this document.
2. You have asked your therapist to clarify anything that you do not understand.
3. You are giving Pediatric Counseling Center your consent to conduct therapy with you and/or your child.

Signature_____Date_____

Client Name _____ Signed by_____
(relationship to client)