General Consent for Communication Guidelines

Roni Caw, PhD, LPC
Caw Counseling, LLC

125 Alpine Circle, Columbia, SC 29223 **Phone 803-779-3548**

Because the nature of communications and technology continues to evolve, it is important that we are clear about how we will and will not communicate with each other outside of the therapy hour.

Please initial all statements below with a yes or no answer.

THERAPY

Phone Sessions:

I am only able to conduct therapy sessions via phone in states where I am licensed, which currently is only in South Carolina. Insurance will not pay for telephone calls. My general rule is that all therapy is done in person unless we have a clear contract that indicates we will talk on the phone. I understand: yes _____ no_____

Skype Sessions:

Skype or other video telecommunication methods such as Face Time are not considered a confidential form of therapy. Therefore I do not conduct therapy session via the internet. I understand: yes_____ no _____

COMMUNICATIONS:

May my office staff and I call you at home? yes _____ no _____. May we leave a message at this number? yes _____ no _____.

May my office staff and I call you at work? yes _____ no _____. May we leave a message at this number? yes _____ no _____.

May my office staff and I call you on your cell phone? yes _____ no _____. May we leave a message at this number? yes _____ no _____.

Please note that if I call you after hours on my cell phone, I cannot guarantee that the phone line is secure and confidential. The same is true if you call me on your cell phone at my office. I understand: yes _____ no_____.

Texting:

As our office uses landlines for the sake of your security and confidentiality, we do not use texting as a form of communication. Texting, like email, is not secure.
I understand: yes_____ no _____

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Facebook:

I will not accept Facebook Friend Requests from you or send them to you while you are an active client. I have a Facebook page, but I will not communicate with you as a client on the Wall of that page or via Facebook messaging.

I understand: yes _____ no _____

Email:

Email is to be used only for the purposes of sending psychosocial educational information. I may take as long as 24 hours to respond. **Regarding canceling an appointment, 24 working hours' notice is required for notification in person or by PHONE.** ***Please call our office at 779-3548 between 9 AM and 12 PM, or between 2 PM and 4:30 PM, Monday to Friday to speak to our office staff. Calls outside of those times will be recorded by an answering service.*** **Email is not to be used for appointments or to communicate emergency or therapeutic information.** If you do send me information via email, know that all communication via the internet is not considered secure and I will not respond to personal information related to your care.
I understand: yes _____ no_____

Payment Methods:

I accept cash, checks and credit cards. If you pay me by check, your check will be deposited into my account. My contracted account for billing purposes is Midlands Psychiatric of Columbia and by nature of payments traveling to the bank and being handled by bank professionals, I cannot guarantee your confidentiality. If you have concerns about this method of payment, you may pay me by cash or credit card. My credit card contracted account for business is also Midlands Psychiatric Columbia. I understand: yes _____ no _____

If we are taking a credit card payment over the phone, our office staff will call you each time a transaction will be made. I understand: yes_____ no _____

I have read and understand all of the above guidelines for communication and consent to follow them in my therapeutic relationship with Roni Caw, PhD, LPC:

Signature _____ Date: _____

Child Therapy Contract Guidelines

Roni Caw, PhD, LPC
Caw Counseling, LLC

125 Alpine Circle, Columbia, SC 29223 **Phone 803-779-3548**

Prior to beginning treatment, it is important for you to understand my approach to child therapy and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Patient-Therapist Agreement. Under HIPAA and the APA Ethics Code, I am legally and ethical responsible to provide you with informed consent. As we go forward, I will try to remind you of important issues as they arise.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and therapist regarding the best interests of the child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's treatment records.

It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has disclosed to me without your child's consent. I will tell you if your child does not attend sessions. At the end of your child's treatment, I will provide you with a treatment summary that will describe what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If I ever believe that your child is at serious risk of harming him/herself or another, I will inform you.

Although my responsibility to your child may require my involvement in conflicts between the two of you, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with me as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from my involvement with your children. In particular, I need your agreement that in any such proceedings, neither of you will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $300.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

- If you decide to terminate treatment, you have the option of having a few closing sessions with your child to properly end the treatment relationship.
- You are waiving your right to access to your child's treatment records**.**
- I will inform you if your child does not attend the treatment sessions.
- At the end of treatment, I will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
- You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.
- If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.
- If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $300.00 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

I have read and understand all of the above guidelines for child therapy and consent to follow them in my therapeutic relationship with Roni Caw, PhD, LPC:

Signature _____ Date: _____

Roni Caw, PHD, LPC
Caw Counseling, LLC

125 Alpine Circle, Columbia, SC 29223 **phone 803-779-3548**

POLICY, FEES, PAYMENT, INSURANCE AND SCHEDULING

The initial fee for services is $180.00 and the follow-up fee is $150.00 for 50-55 minutes. Sliding scale fees may also apply. Please plan to pay the full fee after each session unless otherwise arranged in advance. You will not be billed. However, a copy of your charges and payment record will be made available upon your request. You may pay with cash, credit or debit card, or a check made out to Midlands Psychiatric of Columbia.

Your appointment time is reserved for you alone. Without sufficient prior notice, it cannot be given to anyone else. **You will be charged the full fee of $150.00 for any missed appointments unless our office staff receives a cancellation notice 24 hours in advance or is advised in the event of an emergency.** Appointments will be scheduled after sessions or you can call the office staff at 803-779-3548.

Our office staff will file with insurance companies and they will be glad to provide whatever information your particular plan requires so that you may file for reimbursement. Companies often require that a diagnosis be assigned before they will pay. If you find that this is necessary with your plan, I will advise you of my choice of a diagnosis for insurance purposes.

Insurance companies and policies differ greatly in their choices of what types of providers and mental services are covered. There are sometimes confusing and seemingly arbitrary restrictions on reimbursements. With your permission, our office staff will attempt to provide to you whatever documentation of your services your company requires. If you are relying on your coverage to pay for therapy, you should get direct confirmation from the insurance company that they will pay out-of-network mental health benefits and what percentage they will reimburse. **You are responsible for the full fee at time of service.**

****Please be aware** that using insurance to cover mental health fees is an automatic Release of Information to your insurance company.

I have read and understand this policy

Name _____

Signature _____

Date _____

GENERAL INFORMATION AND CONSENT FOR THERAPY

Roni Caw, PhD, LPC
Caw Counseling, LLC

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For best results and your own welfare, it is important that you understand what it means to be in psychotherapy. Please read the brief description below. If you have any questions or concerns, you are urged to talk about them. If you understand it and you chose to be in psychotherapy as described here, initial each point and sign and date this form. Your signature represents an agreement between us.

1. Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you better understand yourself and others, to help you solve problems that may be limiting your life satisfaction, and to help you better cope with the feelings and challenges that you encounter in your daily life.
   I understand: ____yes ____no

2. The most common form of psychotherapy involves your talking about your feelings, your problems or concerns, and your experience of yourself and your situation. Other common methods involve using your imagination, keeping personal records of your experiences, and trying new or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions or you may be asked to do them at home. **I understand: ____yes ____no**

3. To better understand you, many psychotherapists use a variety of tests or measures of your current abilities and styles of experiencing. These measures are important in choosing the treatment methods best suited to you, and they are also helpful in estimating your progress.
   I understand: ____yes ____no

4. The length of psychotherapy often depends upon your individual needs and the rate of your progress. Many therapists use periodic reviews as a means of evaluating your needs, progress, and satisfaction.
   I understand: ____yes ____no

5. Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by psychotherapy is rare, but you should be aware that it could happen. The most common causes of such damage are poor communication or unethical conduct. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your therapist. If you feel that your therapist has attempted to violate you in any way -- financially, physically, sexually, or otherwise -- you should so inform the state agency responsible for professional licensing.
   I understand: ____yes ____no

6. You always have the right to choose whether or not to continue in psychotherapy. If you feel that you might work better with a different therapist, your present therapist should be able to offer you information on possible referrals. Local mental health agencies are listed in the phone book and they may also offer helpful information. The most common alternatives to psychotherapy are self-help and support groups, bibliotherapy (therapeutic reading), and different forms of religious counseling**.**
   I understand: ____yes ____no

7. The information communicated in therapy must be kept confidential by your therapist unless you grant permission to release it. The only exceptions to this protection of your privacy are dictated by state laws.

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Confidential information may be released WITHOUT your permission if:

- You threaten to harm yourself or someone else and your threat is believed to be serious your therapist is ethically and in some instances legally obligated to take whatever action seem necessary to protect you or others from harm.
- There is suspected child abuse or neglect. Therapists are obligated by law to report this to the appropriate state agency. This law also applies if you report that you have reason to believe another person is abusing or neglecting a child.
- You are in court-ordered therapy and the court wishes to receive some type of report or evaluation.
- You are involved in litigation of any kind and inform the court of the services you receive here (MAKING YOUR MENTAL HEALTH AN ISSUE BEFORE THE COURT), you may be waiving your right to keep your records confidential.
- You lodge a formal complaint against me or make me a party to a legal action.
- You use insurance to reimburse for fees (please see Release of information Form for Insurance Purposes).
- You do not pay your bill and billing information is forwarded to a collection agent.

I understand: ____yes ___no

8. I understand that my therapeutic relationship is with Roni Caw, PhD, LPC. Although the location is at 125 Alpine Circle and other independent therapists practice at this location, I agree to hold harmless any other service provider at this location. **I understand: ___yes ___no**

9. On occasion, a client will request that I release client record information under circumstances that I feel may be harmful to them. Confidentiality laws do not allow me to do so without a court order. This will also apply to a personal request from you or your attorney. **I understand: ___yes ___no**

Your signature below indicates that you have read and understood the above description of psychotherapy. Your signature also indicates that you are now consenting to be in psychotherapy with the understanding that you retain the right to review and revise this decision at later points in time.

_____ _____
Signature of Client or Parent/Guardian Date

South Carolina provides the consumer the opportunity to file inquiries with its Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists. Board offices may be reached at: **South Carolina Board of Examiners, P.O. Box 11329, Columbia, SC 29211-1329.**

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FMLA, Short-Term Disability, Long-Term Disability, Military Compensation Forms

As I am not a medical doctor or a psychiatrist, I do not complete paperwork for FMLA, short-term disability, or long-term disability.

In order to assist military personnel with military compensation forms, all paperwork will be completed in session as a part of treatment.

Your signature below indicates that you have read and understood the aforementioned information concerning requests to complete FMLA, Short-Term Disability, Long-Term Disability, and Military Compensation Forms.

_____ _____
Signature of Client or Parent/Guardian Date