

## **Therapy Consent, Policies & Agreement**

### **PART I: THERAPEUTIC PROCESS**

**BENEFITS/OUTCOMES:** The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients/patients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

**EXPECTATIONS:** In order for clients/patients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

**RISKS:** In working to achieve therapeutic benefits, clients/patients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

#### **STRUCTURE OF THERAPY:**

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaboratively identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy if requested.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client/patient must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

**Anchor & Balance Restorative Services, LLC**  
**Sarah B. Michalowski, DSW, LCSW**  
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drsarah@anchorandbalance.com  
551-333-9679 (google voice)

**LENGTH OF THERAPY:** It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

The length of each session is as follows:

- 30-35-minutes for child therapy sessions, which are weekly or biweekly depending upon the nature of the presenting challenges.
- 45-50-minutes for child, adolescent and adult individual therapy sessions, which are weekly or biweekly depending upon the nature of the presenting challenges.
- 75-minutes for family/couples therapy sessions.
- 75-minutes for EMDR therapy sessions, which are conducted weekly.

**APPOINTMENTS AND CANCELLATIONS:** Your therapy appointment is reserved for you. Therefore, you are responsible for attending each appointment and agree to adhere to the following policy: ***If you cannot keep the scheduled appointment, you MUST notify me to cancel or reschedule the appointment within 24 hours of the scheduled appointment time. Unless there is an emergency, appointments cancelled with less than 24 hours notice will incur a \$75 cancellation fee.*** “Emergencies” are considered events beyond your control such as snowstorms, car accidents, funerals, hospitalizations, or illnesses of the degree which keep you out of work. ***If you cancel or rescheduled more than once, we may re-evaluate your needs, desires, and motivations for treatment at this time.*** Please see the Cancellation Policy Agreement Form.

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

**FEES:** The fees are as following:

- \$100 for each 30-35-minute child therapy session.
- \$125 for each 45-50-minute child/adolescent/adult individual therapy session.
- \$150 for each 75-minute family/couples therapy session.
- \$150 for each 75-minute EMDR therapy session.

Payment is due at the time of service. Acceptable forms of payment are Zelle app through your bank account, exact-amount cash or check (insufficient-funds checks will be returned upon full payment of the original amount plus \$35 for any returned check). Credit/debit card is not accepted at this time, but may be in the future. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the “Appointments and Cancellations” policy above.

The clinician reserves the right to terminate the counseling relationship if more than three sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed.

**TRIAL, COURT ORDERED APPEARANCES, LITIGATION:** Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of \$300 to include travel time, court time, preparing documents, etc.

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**COPIES OF MEDICAL RECORDS:** Should you request a copy of your medical records; the cost is \$1.00 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 2 weeks to prepare medical records.

**PHONE CONTACTS AND EMERGENCIES:** Office hours are Monday – Friday. Weekend appointments may be available upon request and availability of the clinician. Two weekday evenings will be available for appointments. If you need to contact the clinician for any reason please call 551-333-9679, leave a voicemail, and a return call will be made within 24 Hours or as soon as possible. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911 or go to your local emergency room. If there is a reason to believe a child is being abused or neglected, please call the New Jersey Abuse Hotline at 1-877-NJ-ABUSE (652-2873).

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## PART II: CONFIDENTIALITY

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *except* for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's/patient's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.); to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when a your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.
- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Insurance Companies**: If your insurance company requests information relative to payment of your claim, or another process is required to collect unpaid fees for service, or I am involved in any legal defense related to your treatment.
- **Written Request**: Clients/patients must sign a release of information form before any information may be sent or received to/from a third party (psychiatrist, medical doctor, school personnel). A summary of visits may be given in lieu of actual "psychotherapy/process notes", except if the third party is part of medical. If

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therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.

- **Fee Disputes:** In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e. your signature on the “Therapy Consent & Agreement” that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & “No Secret” Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a “secret” that is detrimental to couple’s therapy goal. If one partner requests that I keep a “secret” in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **Dual Relationships & Public:** Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (i.e.: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media:** No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients/patients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client/patient. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.**
  - **Clients/patients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client/patient relationship.** Texting is not a substitute for sessions. **Texting is not confidential.** Phones can be lost or stolen. **DO NOT** communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client’s/patient’s phone.
  - **Do not use e-mail for emergencies.** In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment. **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

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### **PART III: REASONS I DO NOT ACCEPT INSURANCE**

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require “preauthorization” before you can receive services. This means you must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company’s list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.
- **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the therapist justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.
- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies **require** clinicians to give a mental health diagnosis (i.e., “major depression” or “obsessive-compulsive disorder”) for reimbursement. This diagnosis goes in your medical record. Psychiatric diagnoses may negatively impact you in the following ways:
  1. Denial of insurance when applying for disability or life insurance;
  2. Company (mis)control of information when claims are processed;
  3. Loss of confidentiality due to the increased number of persons handling claims;
  4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
  5. A psychiatric diagnosis can be brought into a court case (i.e.: divorce court, family law, criminal, etc.).

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couples therapy. It is important that you’re an informed consumer. This allows you to take charge regarding your health and medical record. At times, having a diagnosis can be helpful (i.e.: child needing extra services in the school system or a person being able to receive disability).

*\* It is also important to note that you do not need to have a diagnosis to attend therapy.*

**Why Clinicians Do Not Take Insurance:** These involve enhanced quality of care and other advantages:

1. You are in control of your care, including choosing your therapist, length of treatment, etc.
2. Increased privacy and confidentiality (except for limits of confidentiality).
3. Not having a mental health disorder diagnosis on your medical record.
4. Consulting with me on non-psychiatric issues that are important to you that aren’t billable by insurance, such as learning how to cope with life changes, gaining more effective communication techniques for your relationships, increasing personal insight, and developing healthy new skills.

After reading my position on why I don’t accept health insurance, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you. You may also check the out-of-network mental health benefits you may be eligible for and I can provide you with monthly statements of services for you to submit to your insurance company.

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**EMERGENCY CONTACT:**

It is necessary that Sarah B. Michalowski, DSW, LCSW of Anchor & Balance Restorative Services, LLC has someone to contact on your behalf. In case of an emergency who should I contact?

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Full Name	Relationship	Phone Number(s)
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Please check here that you agree and sign below. Thank-you.

I agree to allow **Sarah B. Michalowski, DSW, LCSW of Anchor & Balance Restorative Services, LLC** to contact my emergency contact on my behalf in the case of emergency

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Signature	Date
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**PART IV: CONSENT**

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Sarah B. Michalowski, DSW, LCSW**. My signature below indicates that I am voluntarily giving my listed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Sarah B. Michalowski, DSW, LCSW** to provide counseling services that are considered necessary and advisable.
  
2. As described in Part III above, insurance is not accepted. Therefore, I acknowledge that I am financially responsible for payment at the time of services whether or not I choose to utilize my out of network benefits. I agree to pay for services in accordance with the above fees. If at any time I do not pay for services, **Sarah B. Michalowski, DSW, LCSW of Anchor & Balance Restorative Services, LLC**. may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.
  
3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Sarah B. Michalowski, DSW, LCSW to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Sarah B. Michalowski, DSW, LCSW** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session. I realize that my child’s treatment is confidential (please refer confidentiality exceptions). If my child is 14 years or older, I understand that s/he must sign a Release of Information for me to receive information about the treatment unless the child is at risk (Confidentiality Statement) in which case the therapist will notify the proper authorities. My child’s therapist may determine with my child that my participation is needed to treat a specific problem. In that even, I am prepared to participate in my child’s treatment as requested.

*Your signature signifies that you have received a copy of the “Therapy Agreement, Policies and Consent” for your records.*

\_\_\_\_\_  
Client/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Minor’s Signature if 14 years and older

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Minor Child

\_\_\_\_\_  
Witness – Clinician Name, Credentials

\_\_\_\_\_  
Date

**CLIENT/PATIENT COPY**

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\_\_\_\_\_  
Date

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Printed Name of Minor Child

\_\_\_\_\_  
Witness – Clinician Name, Credentials

\_\_\_\_\_  
Date