JULIE OHLINGER, MSW, LCSW
Counseling for Individuals, Couples and Families
Informed Consent for Treatment

Welcome to my therapy practice. I am committed to helping you achieve your desired outcome. A therapeutic situation offers a unique relationship between you and me. In order to begin our therapeutic alliance, I have put together this document to ensure there are no misunderstandings about the various aspects of my psychotherapy services.

Background and Services:
I am a professional therapist in an independent private practice. I have a Masters Degree in Social Work (MSW). I am licensed by the Arizona Board of Behavioral Health Examiners. I offer counseling, psychotherapy and consultation services to individuals, couples and families in the areas of mental health, relationships, adjustments, grief, personal development and career issues. Although I share office space with other therapists, my practice is independent from them. They do not provide care or treatment of any of my clients and I do not provide care or treatment for their clients. There are times when other professionals can and should be involved in the healing process. I may suggest referring to other professional colleagues as needed if I believe that their input will be of benefit to you. I am always happy to coordinate care with your physician or other health care providers if you wish. I am committed to bringing the best knowledge and expertise to this relationship and am always willing to work with you and other professionals to assist in achieving your goals.

Insurance:
I am a contracted provider for a number of third party payors, including Medicare. If you are using one of these plans to pay for your treatment, the terms that govern your benefit plan will apply (i.e. co-payments and deductibles). In all cases, payment of services is ultimately the responsibility of the client, not the insurance company and I will work out a payment plan if necessary. Your consent allows me to share any clinical data necessary to process insurance claims. This can include diagnosis, and depending on the review process, content of our sessions. Please ask any questions you have regarding your insurance company's procedures. Your insurance company or managed care company may limit the number of sessions based on their assessment of medical necessity or other factors. In the event that they will not authorize additional sessions or you exhaust the sessions that your insurance company will provide for the year, you will be responsible for paying for any additional sessions.

Billing:
As a contracted provider: I will collect a copayment and file claims. The insurance will pay their portion to me.
Non-contract insurance (out of network): I will collect the full fee and provide a Super Bill for you to submit for reimbursement from your insurance provider.
Private payment: I will collect the fee at the time of service.

Appointments:

Regular attendance at your scheduled appointments is one of the keys to a successful outcome in therapy. I reserve one hour for each appointment with a client. Appointments canceled at the last minute are very detrimental to our work together and to my practice. Therefore, I prefer 24 hour notice when cancelling an appointment. I have a 24 hour time-stamped message service for just such a necessity. Clients will be billed full fee for missed appointments (No-Show, No-Call) and cancellations made within 2 hours of session. Clients will be charged a partial fee for 2-23 hours notice. Insurance will not pay for this charge.

Availability:

I can be reached at 480-277-9630 (cell). I make every attempt to return calls within the same business day. If I am out of the office and unable to be reached, my voicemail message will indicate the name and number of the qualified professional designated on call for emergency coverage. **In the event of an emergency, please utilize the following resources:** a. 911

b. EMPACT: 480-784-1500
c. Countywide Crisis line: 602-222-9444
d. BANNER BEHAVIORAL HEALTH :602-254-HELP(4357)

Minor Clients:

Minor Clients must have permission and signed authorization from both parents (unless one parent has sole legal custody and provides me with complete official court documentation) prior to provision of counseling service to the minor. Legal Guardians may give permission and authorization but must provide complete court documentation regarding legal guardianship prior to providing counseling service to the minor.
Please note I am not a forensic professional, I do not evaluate, assess or make recommendations regarding custody or visitation. I will refer you to professionals with this expertise.
Although parents of minors have the right to all information presented to the therapist, I generally try to encourage the parents to respect their child's privacy, as the therapeutic alliance may be otherwise compromised.

Privacy, Confidentiality and Records:

Ordinarily all communications and records created in the therapeutic process are held in the strictest confidence according to state and federal laws (42 CFT Part 2). Normally these communications and records cannot be released or disclosed without your written consent. However, in the case of sexual abuse, danger or harm to oneself or others, or abuse of minors or adults, the local law requires that the therapist report these cases to the proper authorities. Other scenarios for disclosure include: when the court issues a court order or the Arizona Board of Behavioral Health Examiners requests records to investigate a complaint.

It is important to be aware that I use a number of electronic tools in my practice including lobby security camera, computers, the internet, PDA, email, fax, telephone and cell phone including texting. I may use these tools to store or communicate information about you and your treatment. While reasonable backup, security and other safeguards are in place, there is always some risk of inadvertent disclosure of information that comes with using these tools. By signing this informed consent, you agree to accept the risk of disclosure that comes with the tools I use in my practice.

During the times when I am out of town or otherwise unavailable, I will typically have another licensed therapist on call for me. I reserve the right to disclose confidential information from your records and our time together, including personally identifiable information to this on-call therapist to facilitate the coverage of your care in my absence.

In the unlikely event of my death, retirement or incapacity, the records for my clients who are actively receiving services will be given to Sabra House, LCSW, 480-451-0819 and/or Suzanne Hyde, LCSW 602-316-4409 both located at 10752 N. 89th Pl. STE 123, Scottsdale, AZ 85260, as a custodian(s) of records to facilitate the continuation of treatment. In such a situation, you have the right to continue treatment with the professional, discontinue treatment, ask for another referral and request a copy of your records. For my inactive client charts, the above named professional(s) or their designates will be responsible for satisfying records requests and destroying records when the legal timeframes for records retention is reached.

Litigation Considerations:

If you become involved in the legal system (divorce, custody, civil litigation, criminal activity, etc.), please know that I will NOT make written recommendations, testify or in any way get involved in your legal proceedings unless court ordered. It may be an inherent conflict of interest for a treating professional to offer evaluations or opinions in legal matters. ***In signing this agreement, you agree that you will not call me as a witness to testify or to expect recommendations or other involvement in your legal activities.***

Therapeutic Relationship:

The client/therapist relationship is unique in that it is exclusively therapeutic. In other words, it is inappropriate for a client and a therapist to intentionally spend time together socially or attend family functions. The purpose of these boundaries is to ensure that you and I are clear in our roles for your treatment and that your confidentiality is maintained.

Therapy is not a guarantee of desired success. Sometimes situations and symptoms do not improve and might worsen in the therapy process. It is my hope and professional commitment that we will address all aspects of the healing process and strive toward reaching your desired treatment goals.

If there is ever a time when you believe that you have been treated unfairly or disrespectfully, please talk with me about it. It is never my intention to cause this to happen to my clients, but sometimes misunderstandings can inadvertently result in hurt feelings. I want to address any issues that might get in the way of our therapy as soon as possible. This includes administrative, scheduling or financial issues.

Informed Consent for Evaluation and Treatment:

I, _____ have chosen to receive psychotherapy services. My choice is voluntary and I am free to terminate therapy at any time. I understand that psychotherapy is a collaborative effort between us. Together I will develop and work toward a plan of treatment with my therapist. I also have the right to accept or refuse treatment. By signing this Consent for Treatment, I am acknowledging that I have read, understood and received a copy of this agreement.

Signature_____Date_____

Parent/Guardian Signature for Minor Client_____ Date_____

Witness_____ Date_____