Center for Grief
and Trauma Therapy

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Informed Consent: Therapy

The policies and procedures of The Center for Grief and Trauma Therapy comply with applicable Delaware and California State regulations. This form is provided to give you important information regarding your legal rights and responsibilities as a client. Please ask for any clarification if you have questions and we will be happy to discuss these with you. We are committed to providing quality service, and in our practice we take steps to support the values of equal opportunity, human dignity and racial / cultural/ethnic/ gender/status diversity. If you feel that you have been inadvertently discriminated against in any way please bring this to our attention immediately.

Client Rights:

- You have the right to choose the provider and modality that best suits your needs.
- You have the right to discontinue treatment at any time for any reason, with or without notice.
- You have the right to ask any questions about the procedures used in therapy. If you wish, your clinician will explain their usual methods of practice to you.
- You have the right to learn about alternative methods of treatment, and we will gladly discuss these at your request during your treatment.
- On occasion, it may be appropriate to refer you to another therapist or related healthcare professional. Such referrals are suggestions only, and the referral does not guarantee any success about an appropriate match or treatment outcome.

Confidentiality:

According to State law, anything you tell your clinician/therapist is considered privileged information and will be held in confidence by them. Your

therapist/psychologist/clinician will not release any information to others about you unless you give them explicit permission to do so in writing. If you request that they release information about you, they will discuss any implications to you of making your records public. Please be aware, however, that there are certain situations in which they are required by law to reveal information without your permission. These are listed below:

- If your clinician comes to believe that you are threatening serious harm to another person, they are required to try to protect that person.
- If you seriously threaten, or act in a way that is very likely to harm yourself, they will have to seek a hospital for you, or call on your family members or others who can help protect you.
- In an emergency where your life or health is in danger and your clinician cannot get your consent, they may give another professional some information to protect your life.
- If your clinician believes or suspects that you, or someone else, are abusing a child, an elderly person, or a disabled person they must file a report with a state agency. This includes perpetrators who have abused people in the past who might still have access to the type of victims (e.g., children).
- Your clinician may occasionally consult with other health and mental health professionals about your case. If so, they will make every effort to avoid revealing your identity. These professionals are also legally bound to keep the information confidential.
- If you are involved in a court proceeding and there is a request for information concerning the services provided to you, your clinician will seek your written authorization prior to disclosing any information. If disclosure is contraindicated, a court order may be needed to protect your records
- Please bear in mind that if you should decide to instigate any legal proceedings against your therapist/clinician/psychologist or any other staff at The Center for Grief and Trauma Therapy, for any reason, you will forfeit your guarantee to confidentiality.
- Although The Center for Grief and Trauma Therapy does not accept in-network health insurance payments, you may request documentation to submit to your insurance company for reimbursement if your policy allows for such. In this case, your documentation will include confidential information, such as your diagnosis, dates of services, name of your clinician, and payments.

Contacting us:

Your clinician will not usually answer the phone when they are with a patient, or in a meeting. When they are unavailable please leave a message on their confidential voicemail. If you cannot wait for them to return your call, and you feel that your situation is an emergency, hang up and dial 911 immediately. You may also go to the nearest hospital emergency room and ask for the mental health professional on call. When your clinician is out of town, they will make arrangements for another qualified therapist to cover any crisis that may arise. That individual's name and contact information will be given to you. There is also an Adult Mobile Crisis Line available at (800) 652–2929.

Additional fee information re: Therapeutic services:

1. Our fee for therapy services is for 45 to 55 minute sessions, which includes the time to discuss scheduling. The fee is the same for children, adolescents and adults. Couple's and family therapy sessions may be extended to 90 minutes upon your request or if previously agreed upon when you schedule your appointment with your therapist. There is an additional fee for extended time services.
2. Your signed agreement for treatment or assessment shows commitment to pay for each therapy session at The Center for Grief and Trauma Therapy at the time of service, unless alternative arrangements have been made.
3. Your fee for therapy services depends on your practitioner and type of service. Dr. Christina Zampitella's individual sessions are $175.00. Couple's sessions are $250.00. Telehealth sessions are $150.00.
4. Services provided by licensed clinicians are $150.00 for individual sessions and $225.00 for couple's and therapy sessions.
5. Services provided by psychological assistants are $125.00 for individual sessions, $200.00 couple's sessions (60 minutes) or $300 (90 minutes), and $225.00 for family sessions.
6. Payments for group sessions are paid as a packaged service, which will vary based on the length of the sessions.
7. Payments for retreats are paid as a package and are determined based on the retreat chosen.
8. · Payments for ADHD/learning disability/psychoeducational/psychological assessments are based on requested testing. These packages and their

   details are available upon request
9. Please discuss any concerns that you might have about payment as soon as they arise.

Cancellations and missed appointments:

1. Appointment times are reserved for you, usually on an ongoing basis. If you arrive late your clinician will likely only be able to see you for the remainder of your session, as they will probably have another appointment scheduled after your appointment. If you arrive more than 20 minutes late then you may need to reschedule, as the work is

compromised by the limited time.

2. Once an appointment is scheduled, you will be expected to pay for it in full unless you provide 24 hours advanced notice of cancellation. Please understand that you will be charged for all missed appointments in full.
3. Sometimes it may be helpful to extend a session. Please note that you will be charged for sessions that are extended. A session will not be extended unless you agree

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Other costs and fees:

1. In addition to scheduled appointments, we charge a fee for other professional services you may need. Other services include report or letter writing, telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other services you may request of your provider.
2. Telephone consultations with you, or on your behalf, that extend longer than ten minutes will be charged on a prorated basis. There is no charge for phone calls about appointments, or regular business matters pertaining to our sessions. **If you elect to communicate with us via e-mail or text, we will assume that you are accepting that confidentiality cannot be completely guaranteed.**
3. Signing this informed consent serves as your consent for us to use office staff to manage billing issues. They are subject to the same confidentiality agreements as we are. They have no access to any clinical or personal information, other than what is needed to bill for services.
4. If you become involved in legal proceedings that require our participation, you will be expected to pay for all our professional time including preparation and transportation costs, even if we are called to testify by another party.

Policies re: Treatment of a minor child:

1. Please discuss with your child's therapist how they will work with your child so that you can be informed of what to expect when you have a child in treatment.
2. Delaware and California Law authorizes the parent(s) or legal guardians to give informed consent for most medical decisions, including mental health treatment, on behalf of the minor. There are exceptions, for which minors may themselves consent. If the minor is age 14 and is mature enough to participate in therapy (per the therapist's evaluation), and the therapist's clinical judgment deems it appropriate to the situation, the minor may be seen without parental consent. However, if there is a way to include the parent(s) and family, that, of course, is the more ideal course of treatment.
3. If the parents are married or not separated, either parent acting alone may consent to mental health treatment for the minor. However, depending on the circumstances, it may be prudent to seek consent of both parents in an effort to include both parents in

the therapeutic process and to have support of both parents in the therapy with the minor. For parents who are divorced, it is critical that we receive a copy of the custody order indicating which parent has legal medical decision-making authority prior to the treatment of the minor. Report of physical custody arrangements does not fulfill this requirement. If there is joint legal custody, either parent acting alone may consent to mental health treatment, unless the joint legal custody order has language to the contrary. A step-parent does not have the authority to make mental health decisions for the child unless he or she has legally adopted the minor. A legal guardian has the same right as a parent having legal custody of a minor to consent to mental health treatment.

4. When a parent/guardian requests treatment of a minor child, it is important that the minor has confidentiality in order for therapy to have the most successful outcome. Therefore, as a parent/guardian, you are giving consent for the minor's therapy to be confidential (between their therapist and the minor).

There are exceptions to this confidentiality in the case:

1. The minor is a threat to his/herself or others;
2. Explaining any mental health diagnoses (i.e., major depression);
3. And periodic summaries of how therapy is progressing. Either you or the therapist may initiate the timing of these summaries as the parent/guardian.

Clinicians are required to intervene if:

1. The minor would present a danger of serious physical or mental health harm to self or others without the mental health treatment.
2. The minor is the alleged victim of incest or child abuse.

Cancellation policy:

Appointment times are reserved for you. Once an appointment is scheduled, you will be expected to pay for it in full unless you provide 24 hours' notice (except in unforeseen circumstances, or if you, or your child, is sick). This means that if you "no-show" for an appointment, you will need to pay for the clinician's time in full.

_____ Initial:

Appointment times are reserved for you, usually on an ongoing basis. If you arrive late, your clinician will likely only be able to see you for the remainder of your session, as they will probably have another appointment scheduled. If you arrive more than 20 minutes late, then you may need to reschedule, as the work is compromised by the limited time.

_____ Initial:

Please understand that you will be charged for all missed appointments in full if you fail to contact us.

_____ Initial:

Telephone consultations with you, or on your behalf, that extend longer than ten minutes will be charged on a prorated basis. There is no charge for phone calls about appointments, or

regular business matters pertaining to our sessions. **If you elect to communicate with us via e-mail or text we will assume that you are accepting that confidentiality cannot be completely guaranteed.**

Initial:_____

Consenting to Treatment of Minors:
In order to ensure parents/guardians consent to and have the opportunity to participate in treatment, we must understand any custody issues. Please initial the appropriate statement:

- Both parents live together and agree to this treatment Initial:_____

- There is a formal or informal custody agreement in place, and we understand that we must provide a copy of the agreement and sign a consent for treatment in joint custody cases.

  Initial:_____

- The parent/guardian signing has sole custody and will provide that paperwork.

  Initial:_____

Your signature below shows that **you have received the Informed Consent for Therapy outlining the treatment policies of our practice, a notice of your HIPAA rights, and the PATIENT FINANCIAL RESPONSIBILITY STATEMENT regarding general financial policies.**

You have also had the opportunity to ask for clarification if there is anything that you do not understand. Your signature below also indicates that you personally accept financial responsibility for the services that you receive and acknowledge that no guarantees have been made to you about your treatment outcome.

My signature indicates that I have read the policies noted above that were provided to me, and that I understand and agree to all of The Center for Grief and Trauma Therapy's Policies regarding treatment, as well as policies regarding financial arrangements for any services that I receive

Client's name:_____
(Please print)

Client's signature:_____ Date:_____

Patient/Guardian Signature:_____
Date:_____

FOR TELEMEDICINE ("TELEHEALTH") CLIENTS

Your rights:

This informed consent procedure ensures that at least all of the following information is given to you or your legal representative verbally and in writing. I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of the psychotherapist, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of intervention (e.g. face-to-face services), I will be referred to a mental health professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth psychotherapy, but that results cannot be guaranteed or assured. I understand that there may be issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for video conferencing. I will not hold this therapist liable for any gathering or use of client information by these service providers.

(5) I understand that I have a right to access my personal information and copies of case records in accordance with Delaware or California law. I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. By signing this document, I understand that emergency situations include if I have thought about hurting or killing either another person or myself, if I have hallucinations (see or hear things others do not), if I have delusions (beliefs others may consider unrealistic), if I am in a life-threatening or emergency situation of any kind, if I am having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 9-1-1 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

The law requires that you sign a written statement prior to the delivery of health care via telemedicine, indicating that your or your legal representative understands the written information provided in 1 through 6 above and that this information has been discussed with me or his/her designee. _____(initial here)

If you have chosen the option to receive services via telemedicine (also known as "online, remote services" or "telehealth"), you should be aware of some specific requirements. First, all services are provided via Zoom and/or VSee, a HIPAA compliant live online meeting site. Should you decide to utilize this service, please note that while I ensure confidential meeting space on my end, you will need to ensure you have a space that is confidential wherever you choose to hold the session. By signing this agreement, you acknowledge that if you choose to have a session where another person(s) can hear you, then the breach of confidentiality is your choice and I am not held liable for such a breach. (initial here) _____

Additionally, you are consenting via written authority to allow contact with identified family and other treating professionals in your local area in case I need emergency backup, or in the case in which you are in need of services beyond the scope of telehealth practice (i.e., hospitalization).

By signing below, I_____(printed name) acknowledge that I have read this informed consent and have received answers to any questions to my satisfaction.

_____

Signature of Client Date:

Signature of parent (2) Date:

Signature of parent (1) Date: