Strategic Solutions

Family, Couple & Individual Therapy

63 Cherry Street

Milford, Connecticut 06460

Telephone (203) 283-9358

Fax (203) 283-9358

Informed Consent Form

1. OFFICE HOURS:
Appointments are arranged for a regular day and time per week and extend to 50 minutes per session. Please arrive on time for your appointment. Twenty-four hour notice is required for cancellations except in the case of an emergency. A cancellation fee of $50 may be assessed for no shows.

2. FEES:
Fees for couple, family or individual sessions are $200 per hour. Group therapy fees are based on a 10-week period. Payment is expected at the time of service by check, cash or credit card unless prior payment arrangements have been made. Strategic Solutions is an in-network provider for Cigna, Anthem Blue Cross Blue Shield, and HUSKY insurances and will bill those companies directly. Strategic Solutions will verify your coverage with your insurance company. Strategic Solutions also recommends you contact your insurance company to confirm what your coverage is and your co-payment and deductible. If Strategic Solutions is out of network for your insurance company, Strategic Solutions will provide you with a bill, upon request, that you may submit to your insurance company for reimbursement.

3. CONFIDENTIALITY:
We will not release any information about your therapy or acknowledge that you are a client of Strategic Solutions unless you give us written permission to do so. Please be aware, however, that the law requires that we (a) report suspected child and elder abuse and neglect, (b) warn the intended victims of a violent crime, and (c) protect clients who are potentially dangerous to themselves or others. If you are involved in a life-threatening emergency and we cannot ask your permission, we will share information if we believe that you would have wanted us to do so or if we believe it will be helpful to you. If you describe unprofessional or unethical conduct by another mental health provider, we may be required to make a report. If you are yourself a health care provider, we may be required by law to report that you are in treatment if we believe that your condition places the public at risk.

4. ACCESS TO MEDICAL RECORDS:
The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. Unless your provider believes viewing your record could endanger your life, your physical safety or the safety of another person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents.

5. REFERRAL SERVICES: We work cooperatively with other service agencies and professionals in the area and will suggest a referral in the event that another agency or professional is better able to help you. When psychiatric consultation or medication seems indicated, we will provide you with a referral.

6. THERAPY PROCESS: Sessions will typically be conducted by a co-therapy team. The partnership provides the best objective understanding of the problem and creative problem solving. Therapy will be focused on the specific concerns that brought you to seek treatment. It will include an emphasis on clarifying and improving family and other relationships in order to achieve your goals. To be successful, therapy requires commitment and effort on your part. We will periodically review whether our sessions are serving your needs. In the event we are unable to be helpful to you, we will suggest other service providers. We recommend that you receive a thorough physical exam and may refer you to a psychiatrist or psychiatric nurse specialist for medication evaluation should this be indicated. In all our professional work, we maintain the highest ethical standards of conduct.

7. BENEFITS AND RISKS OF THERAPY: The possible benefits of participating in therapy may include: • Resolution of the concerns that led you to seek therapy • Developing skills for improving your relationships • Discovering new ways to cope with a variety of emotional pressures • Navigating life's obstacles more effectively • Modifying unhealthy behavior and engrained patterns. In spite of all the possible benefits, it is important to note the possible risks associated with participating in therapy. These risks could include but are not limited to the following: • Therapy may require addressing a variety of intense emotions, as well as difficult relationship patterns. At times, this experience may be uncomfortable. • Therapy can sometimes lead to decisions that may be disruptive for yourself and/or your family. • Some people experience no improvements in their situation.

8. EMERGENCIES: We are unable to provide 24-hour coverage. In cases of emergency and in the event that we are unable to return your phone call in a timely manner, please call 911, contact your family physician, your clergy, the nearest hospital emergency room, or Infoline at 211.

9. YOUR RIGHTS: We view therapy as a collaborative process and are mindful of your right to question and review any part of your therapy, including our policies and procedures.

10. PERMISSION TO OBSERVE/RECORD: I/we, the undersigned, acknowledge that I/we might be asked for permission to give consent separate from this agreement to tape our sessions or to have our sessions observed. I/we can rescind at any time in writing our consent to have sessions recorded or observed.

11. PERMISSION TO CONTACT: I/we, the undersigned, give Strategic Solutions permission to leave messages with members of our household (yes_____/ no_____) and/or on an answering machine at home (yes____/no____) and/or work (yes_____/ no_____) and/or on a cell phone (yes_____/no_____). Strategic Solutions my send me email messages (yes_____/no_____) and/or text messages (yes_____/no_____). I am aware that emails and texts are not secure.

12. PERMISSION FOR THERAPY FROM NON-ATTENDING PARENT: I do hereby state that I am the natural parent or legal guardian of the minor in treatment; therefore, I am authorized to make this request for and give my consent to treatment. The non-attending parent has been contacted and given his/her consent to treatment (yes_____/no_____).

I/we have read and understood the above information.

Client Signature:_____Date:_____

Client Signature:_____Date:_____