Bravely Blooming Consulting, LLC

Therapy Agreement- (Informed Consent)

CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian.

LIMITS OF CONFIDENTIALITY

Noted exceptions to the Confidentiality Agreement are as follows:

Duty to Warn and Protect- When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to
notify the family of the client.

Abuse of Children and Vulnerable Adults- If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances- Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship- Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. **Insurance Providers** (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

*Client Signature_____

*Client's Parent/Guardian (if under 18)_____Today's Date_____

HIPPA

I have read this "Therapy Agreement (Informed Consent)" as well as "Confidentiality Information" forms.

In Addition, I have access to the "CONFIDENTIALITY- HIPPA" information required by law.

*Signature of client_____ Date_____

*Printed Name_____ Date_____

Email: bravelybloomingconsulting@gmail.com **Website**: http://www.bravelyblooming.com
Confidential Fax: 1- (847) 656-2329

Bravely Blooming Consulting, LLC

USING HEALTH INSURANCE

In-Network: Bravely Blooming, LLC is currently in-network with select health insurance companies, and I understand that it is my responsibility as the client to determine whether Dr. Siler's clinical services are in-network with my health insurance plan. Standard sessions are authorized by most health insurance plans for 45 minutes office visits (CPT: 90834). In special situations or due to scheduling limitations, I may choose to request an extended or back-to-back sessions, I understand that this means I am responsible for a co-payment for each 45 minute session segment. I am aware that any claim to insurance includes my consent to release any medical information necessary to process my claim. I understand that this is generally limited to my diagnosis, current procedural terminology for services rendered, contact information and dates of service. If an insurance company requests additional clinical updates or information in order to authorize further services, my provider will let me know, as this may involve providing documentation that ongoing counseling or psychiatric services are medically necessary. I understand that my co-pays are due at the time of service, and that I am responsible for co-insurance payments and for payment of services which are denied by my health insurance coverage. I understand that payments are accepted via cash, check, Chase Quick Pay, or Square Credit card reader.

Out of Network/ Self-Pay Clients: It is the client's responsibility to determine whether my services are in-network with their health insurance plan. For patients, who are not able to use their health insurance benefits, Dr. Siler will provide me with claim information to seek reimbursement from my insurance company UPON MY REQUEST. If I want to work through insurance, it is my responsibility to pay session fees first and submit a claim for reimbursement afterward. Bravely Blooming Consulting, LLC will provide a receipt invoice **for paid services only**. I am aware that any claim to insurance includes my consent to release any information necessary to process my claim. I understand that this is generally limited to my diagnosis, current procedural terminology for services rendered, contact information and dates of service. If an insurance company requests additional information to authorize further services, this may related to providing documentation that counseling or psychiatric services are medically necessary. I understand that payments are accepted via cash, check, Chase Quick Pay, or Square Credit card reader.

*Signature of client_____ Date_____

*Printed Name_____ Date_____

CANCELLATION AND NO-SHOW POLICY

My signature below shows that I understand and agree to comply with the cancellation/no-show policy.
I understand that I will be liable for the full fee of the session **i**f I do not show up for an appointment and do not call, or if I call to cancel with less than 24 hours notice.

Thank you for your consideration regarding this important matter.

*Client Signature: _____

*Client Name (Client's Parent/Guardian if under 18)_____ Date_____

Email: bravelybloomingconsulting@gmail.com **Website**: http://www.bravelyblooming.com
Confidential Fax: 1- (847) 656-2329

Bravely Blooming Consulting, LLC

AGREEMENT TO PARTICIPATE IN PSYCHOTHERAPY

My signature below indicates that I have read this information and that I agree to participate in psychotherapy with Dr. Amber Siler or an associate or supervisee. In addition, I agree to act according to the points covered in this information sheet.

- I hereby agree to enter into therapy on my own free will, and to cooperate fully. I understand that I am free to discuss my concerns with my therapist, before I start therapy. I understand that honesty and sobriety are expectations of behavior during therapy sessions. I am aware that emotional events may be discussed and that, at times, I may experience temporary distress as a part of my recovery and treatment.
- I understand that no specific promises were made to me by Dr. Siler about the results of treatment, the effectiveness of procedures, or the number of sessions necessary to experience an improvement.
- If at any time during the treatment I have any questions, feedback, or would like to change treatment goals, I can talk with my therapist about my feelings and wishes.
- I understand that safety is an expectation of the therapeutic alliance. I am aware that if I behave in a consistently unsafe manner, engage in stalking, or behave in a threatening manner, Dr. Siler has the right to enact immediate consequences. These consequences may range from immediate cancellation of the session at my expense, discontinuation of treatment, referrals provided to other therapists, inpatient hospitalization, and/or police notification.
- I understand that Dr. Siler is not available on a 24h basis, and is not responsible or liable for any decisions that I make to harm myself or others. Dr. Siler will act as a mandated reporter and advocate for a more intensive level of care to ensure my safety (and that of others) in cases where she perceives my behavior or mood state to be a threat to myself or others. I am advised to seek an Emergency Room for clinical emergencies outside of office hours.
- I can request treatment information, or my records at any time, but I understand that Dr. Siler may take up to 30 days to provide me with hard copies of any clinical records. I understand that I am responsible for postage or mailing fees of large records or files.
- I understand that after therapy begins, I have the right to discontinue therapy at any time, for any reason. However, I will make every effort to discuss the reason or any other concerns with Dr. Siler, before ending therapy. In these cases, Dr. Siler will provide me with alternate referral sources upon my request.
- I also understand that I can review this information at any time at Bravely Blooming, LLC website, or contact Dr. Amber Siler at bravelybloomingconsulting@gmail.com

My signature does not indicate that I am waiving any rights. I understand that I have the right not to sign this form.

***Client's Printed Name: _____ Date:_____**

***Client's Signature: _____ Date:_____**

***Legal Guardian's Signature (if client is a minor):_____ Date:_____**

Email: bravelybloomingconsulting@gmail.com **Website**: http://www.bravelyblooming.com
Confidential Fax: 1- (847) 656-2329