



Informed Consent Form

I would like to familiarize you with several points regarding services at the New England Center for Anxiety, LLC.

Psychotherapy Services: It is difficult to fully describe psychotherapy services, as treatment is individualized based on each client's unique situation and difficulties. However, the type of treatment provided at the New England Center for Anxiety is cognitive-behavioral therapy.

Type of Therapy: Cognitive Behavioral Therapy (CBT) is used with clients in the New England Center for Anxiety in order to teach them skills to cope with anxiety-provoking situations. CBT is a treatment method often used to treat mood and anxiety disorders. CBT is based on the belief that our thoughts strongly affect our feelings and behaviors. That is, our behaviors and emotions are not necessarily caused by external factors (people, situations, and events). The benefit to this way of thinking is that we can change the way we think to feel better even if the situation does not change. Similarly, our thoughts and emotions are influenced by our behaviors. As such, changing behavior can have profound effects on mood and thoughts. In CBT, you will find treatment techniques that are cognitive in nature (modification of thoughts, distinguishing among emotions, problem-solving) as well as behavioral in nature (relaxation training, role plays, homework assignments, practice of newly acquired skills). Additional information may be found on the website for the New England Center for Anxiety: www.newenglandanxiety.com.

Risks and Benefits of Therapy: Psychotherapy can have benefits and risks. Since therapy often involves discussing problems and difficulties, you may experience uncomfortable feelings like sadness, guilt, anger, or frustration. In addition, you may feel temporarily anxious or distressed as you begin to confront the objects and situations that you find anxiety-provoking. These short-term discomforts, however, pave the way for long-term reductions in anxiety. Psychotherapy has been shown to have many benefits. Cognitive-behavioral treatments have shown great promise in the treatment of anxiety disorders. Numerous well-designed research studies conducted in the United States and other countries around the world routinely find significant reductions in anxious distress post-treatment.

Overview of Therapy: During your first session(s), your therapist will decide if s/he is the best person to provide the services that you need in order to meet your treatment goals. If therapy is begun your therapist will usually schedule one 45-55-minute session per week at a time that is mutually convenient for you and the therapist.

Professional Fees: Your therapist charges an hourly fee. Fees are assessed and increased, if needed, on an annual basis. In addition to weekly appointments, your therapist may charge fees for other professional services that you may need, though you will be notified of the costs beforehand. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of his/her professional time, including preparation and transportation costs, even if your therapist is called to testify by another

party. Because of the difficulty of legal involvement, your therapist will charge \$200 per hour for preparation and attendance at any legal proceeding. If you would like to request that your therapist attend an off-site meeting, you will need to complete an Off-Site Meeting Request Form. Off-site meetings are not billable by insurance and, thus, will be billed at your therapist's usual hourly rate to be paid in advance of the meeting. The form must be completed at least one week prior to the scheduled meeting.

Limits on Confidentiality: Confidentiality means that any information that is shared with a therapist during the course of treatment will not be shared with others. This helps to promote a trusting relationship between you and your therapist. Generally, your therapist can only release information about your treatment to others if you provide written consent for specific information to be released. However, there are important exceptions to confidentiality. Your therapist may be required by law to break client-therapist confidentiality if:

- ◆ there is reason to suspect that a minor has experienced maltreatment through abuse or neglect
- ◆ there is a strong possibility that you might harm yourself or others if action were not taken, or
- ◆ records are subpoenaed by a court of law.

Contacting Your Therapist: Due to the nature the work, your therapist may not be immediately available by telephone. When your therapist is unavailable, his/her telephone is answered by voice mail. Your therapist will make every effort to return your call within 24-48 hours, with the exception of weekends and holidays.

Emergencies: The New England Center for Anxiety is not a full-service, 24-hour mental health clinic. Therefore, your therapist may not be able to adequately respond to psychological, medical, or other emergencies. Examples of such situations include, but are not limited to, potential suicide attempts, acute psychosis, severe panic attacks, severe distress, adverse reactions to psychiatric medications, violent anger reactions, or any other situation in which you or others feel that you are in need of immediate help. If at any time during the course of your treatment, you experience an emergency, you must call 911 or phone the emergency number of your local hospital or community mental health center.

Cancellations: Once an appointment is scheduled, you will be expected to pay a \$50 missed appointment fee unless you have provided 24-hour notice of cancellation. Although we realize that situations arise that can make late cancellations or missed appointments unavoidable, we require reimbursement for the time that had been reserved for you. Clinicians will be unable to hold a routine time slot for clients who have more than two late cancellations/no shows. We hope you understand and appreciate this policy.

Payment by credit or debit card for outstanding balances including no show/cancellation fees:

Card number: # _____
Expiration date (MM/YY): ____/____
CVV security code: _____
Name on card: _____
Billing street address: _____
City, State, Zip code: _____
Amount to be charged: outstanding balance

"I request that the above charge card transaction be processed in accordance with the card issuer agreement."

Signature: _____

Telehealth Services: Telehealth services are used when clinicians cannot be physically present with you to evaluate your mental health needs. Clinicians may be present at another location and available to serve you through newly available technology. Instead of talking to someone on the phone at another location, Telehealth services use a video camera and computer to send both voice and personal images (pictures) between you and your clinician so not only can you talk to each other, but you can also see each other. This allows your clinician to make a better evaluation of your needs.

Telehealth Procedures: You will be in a private room by yourself. The room must have a computer with a video camera. The clinician will also be in a private room but at another location with the same type of equipment. When the session is ready to begin, your clinician will start the computer and camera so that you can see each other and talk together. You will join the Telehealth session by clicking on an emailed link that is provided to you by your clinician in advance of the session. When the session is over, both you and your clinician will end the Telehealth meeting. Other than you and your clinician not being in a room together, there is very little difference in the session. Clinicians will ask and document clinical information that you share with them, document the service that is provided, and ensure that documentation is included in your clinical record for future reference.

Declining Telehealth Services: Under ordinary circumstances, you and your therapist will discuss the option of Telehealth services (vs. in-person services) and decide on whether it is right for you. If in-person meetings are inadvisable (e.g., amidst social distancing recommendations and/or "stay at home" orders), we will not be able to treat you if you decline Telehealth services. If there are no restrictions to in-person meetings and it is safe to do so, we will be glad to conduct in-person meetings.

When I agree to Telehealth sessions, I understand that:

1. The potential benefit of Telehealth services is that I will be able to continue work with my clinician, avoiding a disruption in my therapy treatment. If I am a new client, then I will be able to initiate evaluation and/or treatment services.
2. The potential risk of Telehealth services is that there could be a partial or complete failure of the equipment/connection being used which could result in my clinician's inability to complete the evaluation or therapy session.
3. I understand that if the Telehealth connection is lost or disrupted for whatever reason, my clinician will reach out to me via an agreed-upon back up mode of real-time communication (e.g., telephone).
4. I accept that Telehealth does not provide emergency services. If I am experiencing an emergency, I understand that I should call 911 or proceed to the nearest hospital emergency room. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support.
5. I understand that there is no permanent video or voice recording kept of the Telehealth health service's session.
 - a. I also understand that I am prohibited from audio- or video-recording my therapy session (for my own personal purposes) on my computer, phone, or other device.
6. All existing confidentiality protections apply.
7. All existing laws regarding client access to mental health information and copies of mental health records apply.

I also understand that I am responsible for:

- (1) providing the necessary computer, camera, and internet access for my Telehealth sessions,
- (2) the information security on my computer, and
- (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my session(s). I also understand that my clinician is likewise responsible for these things.

By signing below, I hereby acknowledge that:

- I have reviewed the above information with my clinician, and all my questions have been answered.
- I hereby consent to receive treatment at the New England Center for Anxiety.
- I understand that consent is ongoing so that I may ask questions or withdraw my consent at any time during treatment by letting the therapist know.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), and providers of any services or treatments I receive. I understand that if payments for the services I receive here are not made, the therapist may stop my treatment.
- I agree to provide my clinician with a back-up contact phone number, in the event of a dropped or disrupted Telehealth connection.
- I understand that Simple Practice is a HIPAA-compliant platform for providing Telehealth, and that it is my responsibility to ensure the privacy of the time and space where I choose to receive my Telehealth session(s).
- I consent to the use of Telehealth services (remote, computer-based treatment).
- I also understand that my clinician may decide to terminate Telehealth sessions if it is determined that my condition, problem, or situation requires a level of care that is unsuitable for a Telehealth mode of psychotherapy.
- I understand that I may resume in-person meetings if my therapist and I agree it is right for me and safe to do so.

I have received a copy of the New England Center for Anxiety Notice of Privacy Practices effective 10/30/2014.

Therapist Contact Information:

Name:

Phone:

E-mail:

Your Name (print): _____

Signature

Date

Therapist

Date