

CAROL GEGENHEIMER, Ph.D., PLLC

Licensed Marriage and Family Therapist
Licensed Independent Substance Abuse Counselor



INFORMED CONSENT FOR PSYCHOTHERAPY

This Informed Consent for Psychotherapy document contains important information regarding your rights as a client engaged in psychotherapy services. Please read it carefully. We will then discuss it and address any questions that you may have regarding the contents of this document.

Psychotherapy Services

People come into psychotherapy to address a wide variety of concerns and to reach individualized goals. These concerns can affect all areas of life. Sometimes working with a therapist regarding problems can be emotionally distressing and may lead to uncomfortable feelings such as sadness, anger, disappointment and guilt. Psychotherapy can also lead to resolution of these problems, improved relationships, or help people cope more effectively. ***There are no guarantees as to the outcome of psychotherapy and you may terminate services at any time.***

Methods of Treatment

The treatment approaches utilized will include Brief Solution-Focused Therapy, Family Systems Therapy, Adlerian Therapy, Cognitive-Behavioral Therapy, and Eye Movement Desensitization and Reprocessing (EMDR). These are therapies commonly used to treat the above concerns and have been researched and found to be effective.

Course of Treatment and Appointments

The first session we will meet together for an initial assessment. You may, if you wish, bring a friend, family member, or significant other person to this assessment with you. During this assessment we will discuss the history of the concerns that you bring to therapy, information about how these concerns affect your life including your thoughts, feelings and behaviors. At the end of our initial meeting we will discuss goals for therapy and create a treatment plan. ***The treatment plan will outline the anticipated course of treatment, including the number of visits. You may, however, terminate therapy at any time.***

Appointments will usually be set for every two weeks (twice per month) but, depending on needs, may be more or less frequent. Sessions are typically 45-minute sessions and will be scheduled at a mutually agreeable time and day.

Policy on Termination of Services

Services may be terminated in two instances:

- (1) When you have reached your goals or decide you no longer need this service or it appears that no further gains can be made at this time, or if you would be harmed by continued care.
- (2) If for some reason I feel threatened or endangered by yourself or someone close to you.

17100 N. 67th Avenue, Suite 400
Glendale, AZ 85308

(602) 938-3323 TEL
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Cancellation Policy

If you are unable to attend a scheduled appointment, *you must provide 24 hours notice of cancellation. If you missed the scheduled appointment or cancel the appointment with less than 24 hours notice, a no-show fee of \$40 will be charged.* However, if the circumstances were out of your control, the fee may be waived.

Professional Fees and Payment

The hourly fee for my services is \$125. In addition to psychotherapy appointments, other services may be provided and will be billed at the same rate. These other services, which you or others may request, may include such things as consultations with other providers, reports and records requests, and court proceedings.

Payment of any insurance co-payment is expected prior to therapy sessions. Your insurance benefits will be reviewed prior to your first service. You should consult with your insurance plan administrator to evaluate any coverage you may have, the limits, and conditions of coverage. If you are covered by a contracted insurance, my office will attempt to seek reimbursement from your insurance carrier. You remain responsible for the full fee due if they do not pay for the service.

If you are experiencing financial hardship after therapy has been initiated, please consult with my office. Financial arrangements maybe made and/or referrals to other low-cost providers for continued care. If you are in a crisis you will not be denied care, regardless of your ability to pay for services.

Emergency Contact Information

In a life-threatening emergency, call 911.

If you are experiencing a mental health crisis, you may contact the county-wide crisis line at (602) 222-9444.

During business hours (9:00 am - 5:00 pm) you may leave a message at the office and it will usually be returned within 48 hours. After hours I may be paged at (602) 938-3323; leave a message including your name and telephone number, push #5 and the system will send me a page.

Client Records

Client treatment records are kept for a period of 7 years after termination of therapy or 3 years after the 18th birthday of the client, whichever is longer. You are entitled to a copy of your records, unless viewing the records would cause emotional harm to you. Upon signing a Release of Information form, records may be sent to other providers as you wish.

If you are a minor, your parents have access to your treatment records. Parents are usually asked to not request to look at the records as doing so may prevent you from sharing those things necessary for you to progress in treatment. A general statement of progress towards treatment goals will be provided to your parents on a regular basis.

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Confidentiality

Privacy between a client and a psychotherapist is protected by law. Information may only be released with written permission except where there are concerns about danger to you or danger to others, if required by court orders, licensing requirements, or for your insurance provider.

If I believe that you may harm yourself or someone else, or if a child or dependent adult has been harmed, I must act to protect yourself and others. This may involve informing the police, reporting information to Child Protective Services or Adult Protective Services, seeking emergent hospitalization and/or requesting a court ordered evaluation for continued treatment.

Acknowledgement of Informed Consent

By signing below, you indicate that you have read, understand, consent, and have discussed this document with me and agree to the contents of this document. By signing this document, you are agreeing to begin treatment.

Client _____
Print Name \ Signature _____ Date _____

Legal Guardian _____
Print Name \ Signature _____ Date _____

Witness _____
Carol Gegenheimer, Ph.D., LISAC, LMFT \Signature _____ Date _____