Anne Gordon, LCSW, LMFT, LAC, PC
101 E Broadway, Suite 601, Missoula, Montana 59802
(406) 370-6251
annegordon@annegordontherapy.com

Informed Consent Agreement

These guidelines have been written to inform you, the client, about the basic terms, conditions and professional practices that promote a successful therapeutic experience. Please ask for clarification on any issue that may concern you. **Please initial each blank space if you understand and agree with what is stated.**

Confidentiality: In accordance with Montana law, the information disclosed by you in therapy is confidential and is not released or accessible to anyone else without your written permission. By law, the following exceptions apply and may require relevant information be disclosed to others: (1) danger to self or others, (2) when a child, disabled person, dependent adult, or elderly person is physically abused, sexually abuse, or neglected, (3) when a court of law issues a legitimate subpoena, and (4) when a collection service is required for unpaid bills. _____

_____ I acknowledge I have received a copy of the Health Insurance Portability and Accountability Act (HIPAA) Notice of privacy practices, which informs me of my rights regarding Protected Health Information (PHI).

_____ I understand that my insurance company or other third-party payer may be given information about the type of therapy I receive, dates of service, cost of service, diagnosis being treated, interventions being used, progress to date, overall prognosis, etc. as means to determine pre-authorization and ongoing treatment per insurance policy.

_____ I understand that my therapist may discuss my case in a confidential manner for the purposes of clinical consultation, with all information being de-identified.

——-I understand that if I chose to communicate via social media venues, the internet, Skype, etc. in reference to psychotherapy services, that sensitive information may be compromised. I understand that I am fully responsible for this risk because confidentiality can't be guaranteed.

Legal Proceedings and Court Involvement:

——- I understand that the goal of therapy is not to address legal issues, and therefore I agree not to involve Anne Gordon in any legal or court proceedings.

_____ I understand that if during therapy, I become involved in any legal proceedings, I will immediately inform Anne Gordon. However, if Anne Gordon has to participate in any legal proceedings, including preparation and transportation time, even if called to testify by another party, I am responsible for all associated costs which are **$300 per hour.** This will also include payment for Anne Gordon to seek consultation with her own legal counsel.

In Case of Emergencies:
Please call Anne Gordon at (406) 370-6251. During planned times away from the office, a colleague will be on call and the number will be posted both on voice-mail and the office door. If you are unable to reach Anne Gordon directly by phone or through email, please call 911, The National Suicide Prevention Lifeline at 1-800-273-8255 (TALK), the toll free crisis contact for Missoula/Hamilton at 888-820-0083, or go to your nearest emergency department. **A**nne Gordon's office hours are 8:00am- 6:00 p.m. Monday - Thursday only. Messages left on Fridays are returned the following Monday.

Payment of Services: Please read and initial each of the following:

_____I understand that being financially responsible for therapy is a key component of maintaining a therapeutic relationship.

_____ I agree to pay in full at the time of service for services rendered by my therapist. Payments can be made by check, cash, debit, or credit cards. There is a $15 fee for any bounced or returned check.

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_____I understand the fee for a 30 minute individual session is $100.00, the fee for a 45 minute individual session is $125.00, the fee for a 60 minute session is $145.00, the fee for an initial diagnostic interview/session is $175.00, and a family session is $155.00. A minimum of $75.00 per hour is charged for written documents. I also understand that I am responsible for any and all bills that my insurance does not reimburse.

_____ I understand that cancellations of therapy appointments must be made at least **24 hours in advance** and that I will be charged $100 for missed appointments or cancellations less than 24 hours in advance. I will notify by phone or text as soon as possible so that my scheduled time may be utilized by another person. Allowances will be made for emergencies pending a discussion. I also understand that insurance companies do not pay for missed sessions and therefore I am responsible for the full session fee.

_____I understand that unpaid balances, inconsistent attendance, or no-shows, may lead to a temporary suspension or discontinuation of therapy.

_____ Unpaid balances within 90 days of treatment may be turned over to a collection agency. I will be notified prior to this occurring to give an opportunity to pay the outstanding balance. I understand that unpaid balances may result in disclosure of my name, telephone number, SSN, and address to a collection agency or small claims court. I understand that I am responsible for all collection fees, including court costs and reasonable attorney's fees.

Your rights: You have the right to:
_____ Participate in treatment decisions and in the development and periodic review and revision of your treatment plan.

_____ Refuse any recommended treatment or withdraw informed consent to treatment and be advised the consequences of such refusal or withdrawal.

_____ Personally request to view your records. If Anne Gordon feels this may negatively impact your progress, she will discuss this decision with you. All records will be maintained for 7 years from termination of services.

Treatment Outcome:
There are no guarantees that treatment will be successful, although most clients do make significant progress. The length and outcome of treatment is based upon your motivation for and commitment to treatment, complexity of symptoms, and other factors.

_____I understand that I have voluntarily chosen to engage in therapy and I may terminate therapy at any time.

_____I understand that during the course of therapy, upsetting issues may be discussed. I further understand that this may be necessary to help resolve the presenting problem.

I have read and understand all of the terms and conditions stated above and have received a copy of the HIPAA notice. I understand and agree to the terms and conditions of this agreement.

_____ _____
Signature Date

_____
Signature of Therapist