



CONSENT TO TREATMENT

Process of Therapy/ Benefits, Risks, Alternatives

Most people who participate in behavioral or mental health treatment benefit from it. Like most kinds of health care, this kind of treatment requires a very active effort on your part. In addition, there may be certain kinds of risks involved. Nevertheless, most people find the benefits outweigh any such risks. In fact, sometimes there can be more risks associated with not participating in therapy.

During therapy, remembering or talking about unpleasant events and feelings can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia or other problems. Attempting to resolve issues that brought you to therapy in the first place may result in changes that were not originally intended. Change will sometimes be easy and swift, while other times it may be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. It is my ethical responsibility only to provide therapy if I honestly believe that I can be of significant help and that the kind of therapy I provide is appropriate and likely to succeed. If for any reason, I feel that this is not the case, I will discuss this with you and refer you to whatever treatment believe would be most helpful. You decide how long your treatment will last. I want you to talk to me about it when you are thinking that you are ready to end therapy, so that the ending will be as helpful to you as possible. Treatment plans suggested procedures and goals will be discussed and arrived at mutually. We may consider supplementary treatments (i.e.: medication evaluation, self-help groups, etc.) the possible indications for which will be discussed fully.

Policies of My Practice

1. **Sessions:** Appointments last 50 minutes unless longer sessions are agreed upon in advance.
2. **Fees:** Fees are determined on an individual basis and are payable at the session or in advance. Established fee is based on your present ability to pay within my current fee range. Fees are reviewed yearly and periodically increased. If paying with credit or debit cards, by signing this consent, you are authorizing Maureen Fiorelli to store your information for use as payments are due.
3. **Insurance:** If you are planning to use insurance, you will need to consult your insurer about reimbursement for your sessions. I will provide you with a monthly billing statement that you can submit to your insurance company for reimbursement.
4. **Cancellations:** A 48-hour notice of cancellation is required. You will be charged for the full session if you do not cancel your appointment within at least 48 hours' notice. If you no show for a session, you will be charged for the session.
5. **Phone Contact:** Phone contact between sessions is generally limited to issues like rescheduling appointments unless we schedule a 50-minute phone session, for which you will be charged.
6. **Scheduling:** Please notify me as far in advance as possible if you will not be able to make your regular appointment time, will be on vacation or if you would like to take a break from therapy.
7. **Confidentiality:** All information re: clients is held in strict confidence. Exceptions occur only when:
 - A. The client authorizes release of information in written form.
 - B. A court of law orders the release of information.
 - C. The client presents a danger to self or others.
 - D. Child abuse or neglect is suspected.
 - E. Elder abuse is suspected.
8. **Emergencies:** If there is an emergency during our work together where I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may contact the police, hospital, or the person whose name you have provided as an emergency contact and/or other persons previously identified by you.

9. **Social Media:** I do not accept friend or contact requests from current or former clients on any social networking sites (Facebook, LinkedIn, etc.). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality. It may also blur the boundaries of our therapeutic relationship. You are welcome to follow the Enso business pages (Facebook, Google+) as they can be helpful resources. Clients often choose to refer friends and acquaintances to me for services. Of course I am grateful for this, but please consider whether the referral will feel right for you.
10. **Confidentiality of E-Mail, Cell Phone, and Fax Communications:** Cell phone, cordless phone, emails and fax communication can be relatively easily accessed by unauthorized people. Therefore, the privacy and confidentiality can be easily compromised. E-mails, in particular, are vulnerable to such unauthorized access because the servers have unlimited, direct access to all e-mails. Faxes can be sent erroneously to the wrong address.
Please notify me at the beginning of therapy if you decide to avoid or limit the use of any or all of the above-mentioned communication devices. Please do not use e-mail, faxes or text messages in emergency situations. In addition, text messaging with a phone device is also not completely secure and confidentiality can be compromised. If using text messages, please limit use to scheduling issues only.
11. **Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce or custody suits, injuries, lawsuits, etc.) neither you nor your attorney nor anyone else acting on your behalf may call on me to testify in court or at any other proceeding, nor will a disclosure of psychotherapy records be requested.
12. **Mediation and Arbitration:** All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before and as a pre-condition of arbitration. The mediator shall be a neutral third party chosen by agreement between you and me. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Philadelphia County in accordance with the rules of the American Arbitration Association. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney's fees. In the case of arbitration, the arbitrator will determine that sum.
13. **Telephone Contact:** If you need to contact me between sessions, please leave a message on my voice mail and your call will be returned as soon as possible. I check my messages a few times a day (but never during the nighttime) unless I am out of town. I check my messages less frequently on weekends and holidays. If an emergency situation arises, please indicate that clearly in your message. I may not be able to handle immediate emergencies that may arise during the course of treatment. If you need to talk to someone right away, please call the Psychiatric Emergency Services at 215-686-4420, or the police at 911.
14. **On-line Therapy Waiver/Agreement:** I confirm that I am beginning a course of online counseling with Maureen Fiorelli, MFT, some of which may be online. I am hereby verifying that Maureen has informed me that although Zoom is considered encrypted, and thereby HIPPA compliant, contact through the internet cannot guarantee full confidentiality. I also commit to my own responsibility to be mindful of my own location and surroundings for added privacy and confidentiality during online sessions. In addition, I certify that I have been given the HIPPA Notice of Privacy Practices and that if I agree to credit card information storage, my information will be securely stored and processed through Office Ally which guarantees all information is encrypted and HIPPA compliant.

Acknowledgment/Consent: I have read and understand the above information and policies. I agree to abide by the contents and terms of this agreement and further consent to participate in treatment.

Signature of Client _____ Date: _____

Printed Name of Client _____