Chicago BodyMind Wellness Studio

3525 West Peterson Ave. Suite 605
Chicago, IL 60659

Therapist Name:

_____

INFORMED CONSENT
for psychotherapy services

Thanks for your interest in working with me for psychotherapy services. Please note that I specialize in Body-Centered Psychotherapy yet also utilize more traditional approaches including cognitive behavioral and psychodynamic strategies.

Nature of Services: Body-Centered Psychotherapy are processes that focus on the integration of mind and body and support the mental and physical health of clients. These services are generally unlike any services you may receive from a physician or traditional cognitive-based therapist in that they require your active participation and engagement.

Therapy has both benefits and risks. Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness), the recall of unpleasant memories or the recognition of unpleasant or uncomfortable sensations in the body. Potential benefits include reduction in feelings of distress, better relationships, better coping skills, and resolution of specific problems. Given the nature of therapy, it is difficult to predict what exactly will happen, but I will do my best to make sure you will be able to handle the risks and experience at least some of the benefits. However, this remains an inexact science and no guarantees can be made regarding outcomes.

There are a variety of techniques that can be utilized to deal with the issue(s) that brought you to therapy. Body-centered Psychotherapy gives you the option to utilize Mindfulness, body-centered (body-awareness) therapy including Somatic Experiencing, Hakomi, imagery, somatic touch, or Energy Psychotherapy techniques. While there is significant empirical evidence supporting the use of these methods as beneficial to the wellbeing of clients, there is limited rigorous scientific study of the effectiveness of some of these methods. Your agreement to use any or all of these methods signifies your recognition of these systems as "experimental" or "unproven," separately or used together, and the willingness to assume the risks inherent in such methods. Each method will be explained to you beforehand, and at any time during the therapeutic process, you may decline or terminate the use of any method.

Initial: _____

Licensing and Credentials: Your consent to seek therapy services from me includes your understanding that my credentials include:

_____. Please know that I do work within the guidelines and ethics of these credentials.

Consultation, Supervision, & Administration: I meet regularly with a licensed professional for the purpose of supervision and consultation. Information about you may be discussed in confidence, without revealing your identity, with other professionals in consultation, for the purpose of providing you the best possible service.

I also contract with an administrative assistant to process billing to insurance. This colleague has pledged to strictly uphold your confidence when processing your billing and may, when needed, contact you regarding any billing needs.

Use of Client Scenarios during Training: Due to the growing popularity of body-centered psychotherapy I am frequently called upon to give presentations or do trainings for other professionals. As part of these trainings I may refer to client challenges or successes, but never with any specific identifying information regarding the client.

Adjunct Therapy & Collaboration with Primary Therapist: If you are seeing me as an adjunct therapist (i.e. in addition to your primary therapist), I will require that you sign an Authorization for Release of Information form so that I may speak with your primary therapist. In addition to fulfilling the ethical requirements of my professional license, this communication also helps me to clarify roles and responsibilities and establishes a clear line of communication between myself and your primary therapist in order to more efficiently serve your needs. In the event that I am fulfilling the role of Adjunct Therapist, *your primary therapist is responsible for helping you during emergency situations.*

Confidentiality: Information obtained in the therapy session or in written form will **not** be disclosed to any outside person(s) or agency without your written permission except under the following conditions:

- It is determined that you are a danger to yourself or to others. (If this is so determined, your emergency contact will be notified and you will be immediately required to begin attending an IOP, PHP or be admitted as an inpatient as we will determine together)
- Mandated reporting of physical or sexual abuse of a minor
- You give written consent for your records to be released
- Your records are subpoenaed by a court
- You have initiated a lawsuit
- Information necessary for supervision or consultation
- Other circumstances as required by law
- To process your billing---my administrative assistant has committed to uphold your confidentiality beyond releasing your information to BCBS

If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize release to other parties.

Initial: _____

Body-Centered (Body-Awareness) Therapies: Body-centered/somatic therapies include physical movements and these practices may cause strong emotional content to arise. As is the case

with any physical activity, the risk of injury, even serious or disabling, is also always present and cannot be entirely eliminated. If you experience any pain or discomfort, you should immediately inform me. This therapy is not a substitute for medical attention, examination, diagnosis or treatment. It is your responsibility to determine whether you are physically or emotionally able to participate in any body-centered therapy Somatic Experiencing.

Initial: _____

Use of Therapeutic Touch: As part of the therapy process, the occasional use of therapeutic touch may be indicated. Therapeutic touch is always respectful and honors appropriate boundaries. You will be asked your comfort level with being touched and may decline the use of touch at any time during the therapeutic process.

Initial: _____

Time Parameters: Individual appointments are typically scheduled for 50-minute or 75-minute segments. I will also schedule 90-minute sessions when needed.

Payment Policy. As a courtesy we will bill Blue Cross Blue Shield PPO or Blue Choice for services rendered. For any other insurance coverage, you will be asked to pay the full fee at time of service via check, cash or credit card, and will be given an invoice that you can submit on your own for reimbursement. We ask that at each session you pay your co-pay. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300 you may be asked to suspend future sessions until the balance can be paid.

Cancellation Policy. If you find it necessary to cancel an appointment, please contact me at 773-370-2464 at least 24 hours in advance. ***Cancellations with less than 24 hours of advance notice will be charged a $50 Fee for the first missed session and then your full fee for the subsequent session.*** I may also terminate therapy or rescind your regular appointment time in the event the client has missed 3 appointments without calling to cancel 24 hours prior to the scheduled appointment. Initial:_____

Records: Some of your records may be maintained electronically in password-protected files on my computer. You have a right to request your records. As a minor, your parents or legal guardians also have the right to request your records.

Electronic Transmission: I cannot ensure the confidentiality of any form of communication through electronic media. You are advised that any email sent to me via a computer in a work-place environment is legally accessible by an employer.

Use of Electronic Communication: I am available via text or email for scheduling and requesting contact. No therapy will be done via email or text message due to the ease of misinterpretation of the written word. Any information sent via email or text will be acknowledged and discussed at your next appointment. Electronic communication will be responded to within 24 hours Monday through Thursday.

Social Networking Policy: For the sake of your privacy and mine, and in order to maintain appropriate professional and ethical boundaries, I do not connect with or respond to invitations from any clients via social networking sites such as Facebook, LinkedIn, Twitter, Instagram, etc. If you choose to participate in a blog or professional page which I have created on such a site, where you are automatically connected, you take full responsibility for any related confidentiality concerns.

Emergencies: If an emergency situation arises for which you feel immediate attention is necessary, and I have not responded to your call or text within 15 minutes, please contact emergency services (911) immediately or go to your nearest hospital emergency room. You may inform me via email, phone or text of the situation and schedule a standard session at my office to follow up. Calls are returned within 24 hours Monday through Thursday.

Physical Health: It is very important that you determine whether any of your current concerns are biochemical or physiological in origin so that you obtain medical diagnosis and treatment. Therefore, if you have not had a physical in the last 6 months it is recommended that you do so. I also highly recommend that you inform your physician and any other medical or alternative practitioners that you are working with me.

Continuation of Services: In the unlikely event that I am incapacitated and unable to provide ongoing services, another practitioner at the Chicago BodyMind Wellness Studio will provide those services or help you with referrals to another practitioner. They will maintain your records for a period of 7 years. They may be contacted at www.cbwstudio.com.

Release: I release the CBWS from responsibility for any injury resulting from my leaving counseling/therapy against clinical advice, from not following clinical advice, or from not informing my clinician of pertinent issues.

I have read, understood, agree, and consent to the above conditions of service stated. I have also had the opportunity to ask questions about and understand these policies.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

(**For Minors Only) I hereby grant permission to (therapist) _____ and the Chicago BodyMind Wellness Studio to provide psychotherapy including body-centered therapy services to my child,

_____ _____

Parent Signature Parent Printed Name & Date