Virginia Ayres, Ph.D.,
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Informed Consent for Participation in Treatment

Welcome to my practice. Please read this consent form carefully as it describes the policies and procedures followed by this office. You may keep a copy of this form. Your signature indicates that you have read, understood, and agree to abide by its terms.

Description of Services The nature of psychological services provided to you will depend on your needs and will involve a collaborative effort, requiring active work from both of us. Effective services involve a dialogue between psychologist and client. You are encouraged to discuss any questions or concerns with me as they arise. Goals of treatment will be determined collaboratively and will depend on the individual. You can also refuse to participate in treatment at any time as all treatment is conducted only with your consent.

You have the right to understand fully the nature and objectives of therapy and to question me about any aspect of your treatment. Together, we will determine a written list of specific goals that you hope to achieve in treatment. You will be interviewed and asked to fill out questionnaires to assist in determining how best to help you. You may work on tasks outside the sessions such as thinking about a particular issue, reading relevant material, or practicing something we have discussed in a session.

The duration of treatment is different for each person and can be difficult to estimate; I will address any concerns that you have about this. If you are not feeling satisfied with your treatment for any reason, you are asked to discuss this directly with me. I will work with you to uncover what might be preventing progress, modify goals with you if appropriate, and will make a referral for you to (an)other professional(s) if necessary.

There are risks and benefits to therapy. Many people find that they have a temporary increase in their level of distress when beginning psychotherapy, because the process of working on issues can be difficult. Therapy often leads to a decrease in symptoms, better relationships, and reductions in feelings of distress, but there are no guarantees of what you will experience or how effective it will be for you.

Confidentiality Your talks with me are confidential. The **Notice of Privacy Practices** provides detailed information about how private information about your healthcare is protected and under what circumstances it may be shared. Ethical and legal statutes prohibit my sharing information you tell me without your written consent. I may honor your verbal request to release information, if necessary. I may also discuss information from your record with another appropriate professional, if I deem necessary, for the purpose of clinical consultation regarding difficult issues. Your identity, if such consultation occurs, will not be revealed. **HOWEVER**, below are the circumstances in which confidentiality will be breached:

- If you threaten bodily harm to yourself, another person (s), or group, the intended victim(s) and appropriate professional worker or public authority will be notified. If you threaten to harm himself/herself, I may be obligated to seek hospitalization for him/her/them or to contact family members or others who can help provide protection.
- Disclosure (or report filing) to appropriate state agency will occur in cases of alleged abuse to children, elderly, or disabled persons.
- Your file must be handed over if a court of law issues a legitimate subpoena.
- Other exceptions may exist if you make your mental status a court issue.
- Providing information as part of professional standards review or utilization review.
- In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

THIS OFFICE IS NOT RESPONSIBLE FOR ANY DISSEMINATION OR DISCLOSURE OF YOUR CONFIDENTIAL INFORMATION ONCE WE PROVIDE SUCH INFORMATION, AT YOUR REQUEST, TO YOUR HEALTH INSURER, EMPLOYER, OR OTHERS THAT YOU REQUESTED.

If you need additional information, formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. Any information disclosed will, if possible, be limited and written and documented in your record.

Professional Records The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Appointments The frequency and number of appointments is determined by your specific needs. Usually we meet on a weekly basis, however, if an emergency arises, the plan may change. You must notify me 24 hours in advance if unable to keep a scheduled appointment or you will incur a fee (see financial policy paragraph). Hours of operation are Mon.-Thur. 930-430 with weekends and evenings available as arranged.

Fees and cancellation policy

- Payment is due at the time of service. A check, cash, or a credit card is accepted. Fees are set according to services provided. I have not contracted with any insurance companies and am considered an "out of network" provider. It is your responsibility to contact and manage reimbursement for services from your insurance carrier. I will provide you with a superbill for you to submit to insurance. There are fees for writing treatment summary reports (for example, if you need a report sent to a psychiatrist or physician) and for reviewing records sent from other professionals. You are also expected to pay for legal proceedings requiring my participation. Insurance typically will not pay for these services, although they can require considerable time.
- Please cancel appointments 24 hours in advance or a fee of ½ your session cost will be incurred for the first occurrence and 100% of session charge for any occurrences thereafter. Your insurance carrier will not pay for this cost.
- If your account is delinquent for 120 days, you agree to be responsible for any reasonable collection costs or attorney fees incurred in collecting delinquent accounts. Your name may be released to a national credit reporting agency to collect on accounts.You may be charged interest on the outstanding balance of your account if it is not paid in full within 30 days of termination of therapy.

Fees:

Initial Assessment Session (75-90 min.):	$185
Therapy Session (60 min.):	$160
Therapy Session (45 min.):	$120
Therapy Session (30 min.):	$80
Conjoint Session:	$185
Legal proceedings	$400 per hour

Report Writing/Review Records/Phone conversations (over 10 min): session fee rate adjusted for time spent. Group Treatment fees will be set at the beginning of treatment.

Calls/Emergencies You may contact me at my office number 24 hours a day, leaving a message on voicemail if I am unavailable. I will return your call as soon as possible during business hours. If you are unable to reach me directly in a time of emergency, it is recommended that you:

1) call 911 or
2) go immediately to your nearest emergency room

Other resources you may call:

- Cuyahoga County Crisis Line: 216-623-6888
- National Suicide Hotline: 800-273-TALK
- Crisis Text line, text HOME to 741741 or go to http://www.crisistextline.org/ or you can chat online at http://www.crisischat.org/

Your signature below assures me that you have read, understood, and agree to the limits of patient confidentiality and other policies outlined in the 1) **Informed Consent Form for Participation in Treatment,** 2) **Notice of Privacy Practices** form and how information about you may be used and disclosed, 3) **Social Media policy,** and 4) that you consent to treatment and the provisions in the forms listed (1-3).

Having provided as accurate and complete a medical and personal history as possible, I hereby authorize Virginia Ayres, Ph.D. to provide psychological treatment as deemed necessary.

I have received a copy of and agree to the information contained within these documents:

1. Participation in Treatment Consent **Yes:** **No:**
2. Notice of Privacy Practices **Yes:** **No:**
3. Social media policy **Yes:** **No:**

Print Name:

Signature: **Date:**

Psychologist Signature: **Date:**