**Cheshire Psychological and spiritual health services**

**DEBORAH C. Cheshire, Psy.D, PLLC**

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**Informed Consent for Participation in Psychological Treatment**

**What You Can Expect from Treatment**

Psychotherapy sessions will last 55 minutes. We will schedule a mutually agreed upon regular time. During our work together, I will utilize interventions from a variety of theoretical perspectives including cognitive-behavioral, interpersonal, spirituality, mindfulness, and solution-focused. Sessions typically consist of focused discussion regarding the circumstances for which you are seeking assistance and may incorporate breathing exercises, yoga postures, and prayer dependent on your need, comfort, and any other circumstances. When working with children, I rely heavily on play therapy interventions including art, music, games, role playing, and stories.

Psychotherapy is not a substitute for medication under the care of a psychiatrist, nurse-practitioner or medical doctor. While our psychotherapy sessions will address social, emotional and personal issues, it may be required for you to consult with a specialist for pharmacotherapy in addition to our work.

You understand that I follow the laws and professional regulations of the States of Texas and New Hampshire; I have current and active licenses in both of these states.

**New Hampshire Board of Mental Health Practices:** The Licensing Board requires that I inform you of the following:

* You and your child have the right to mental health assessment and diagnosis with an explanation that makes sense to you.
* During my vacations a licensed colleague will cover my practice for therapy clients. This professional may be given relevant information about your case, if necessary and with your permission.
* In the event of my death or disability, my records will be entrusted to a licensed colleague who will proceed in accordance with proper confidential archiving of your record.
* Any sexual contact between a psychotherapist and a current or former client, or parent of a client, is prohibited.
* Should you be dissatisfied with my work, please bring this to my attention so that we may discuss your concerns and your options.
* You have the right to obtain a copy of the American Psychological Association’s code of ethics that governs my work.

**Confidentiality**

What you and I discuss during our sessions will be kept confidential and private, with some exceptions. Information will not be released orally or in writing except in one of the situations listed below:

* With your written consent, in order to provide record to third parties.
* With your written consent, in order to coordinate care with other health care providers or educational teams.
* If there is reason to believe that your child’s physical or psychological health is in jeopardy.
* If there is reason to believe that your child is at risk for harming other people or property.
* If I and/or my records concerning our work are subpoenaed by a court order.

Also, in order to maintain my license to practice psychology in NH and to improve my clinical skills, I am required to consult with licensed colleagues about a sample of my clients. Identifying information is not revealed during these consultations, and my colleagues are bound by the same laws of confidentially that I am.

**Confidentiality for Children in Individual Therapy**: As with adults, it is very important for children and teenagers in individual therapy to believe that they can trust their therapist and that the therapy session will remain confidential. Therefore, depending on the age of the child my policy is to share with caregivers general themes of a child’s therapy session and recommendations for how caregivers can help the child. Exceptions to this general rule include when the child is very young or if I believe that the child has been harmed or is at risk for harming him/herself or someone else.

If you choose to email me from your personal email account, please limit the contents to basic issues such as cancellation or change in contact information. I will respond with an acknowledgement of receipt of such emails, but will not engage in communication requesting guidance and/or clinical recommendations.

If you call me, please be aware that unless we are both on land line phones, the conversation is not confidential. Likewise, text messages are not confidential.

**Social Media**

It is important that you and I keep the integrity of our therapeutic working relationship. For this reason, I will not accept any invitations via social networking.

**Telephone and Emergency Procedures:**

In a life-threatening emergency please take yourself or your child directly to your local emergency room or call 911. Leave me a voicemail afterwards, letting me know what has happened. If you have an urgent situation, leave me a voicemail stating the situation and the best way I can reach you. I will make every effort to return your call that day.

**Payment for Services**

Payments for psychotherapy services must be made prior to the time of each session. I only accept Self-pay. You will be provided a link to PayPal or may write a check. Current fees are as follows: intake sessions: $ 160.00 per session; follow-up sessions: $140.00 per session.

**Advantages of Self-Pay**

1. Paying for psychotherapy out of pocket minimizes the exposure of your protected health information (PHI). Whenever you use insurance benefits to cover psychotherapy, the provider, albeit with your consent, has to release certain types of information to the insurance carrier in order to a) verify your eligibility for coverage, b) pre-authorize services (if applicable), and c) to process claims to obtain payment. As the result, the provider informs the insurance carrier of such personal matters as the nature of the issues you struggle with (presenting problem), psychiatric diagnosis, your treatment plan, and prognosis. In the event of Self-pay, your therapy remains completely private (with the exceptions to confidentiality such as in the event of persistent suicidal ideation, etc.). No reports of your treatment are shared with your insurance and all records remain with the therapist only.

2. Furthermore, the advantage of Self-Pay includes the fact that no records of therapy exist in the Medical Information Bureau. MIB records of your therapy could potentially compromise your ability to get current or future life, health, disability, or long-term care insurance. Self-Pay, thus, involves no psychiatric diagnosis code. If, however, you were using your insurance benefits, you would have to be assigned a psychiatric diagnosis in order for the provider to justify the medical necessity for the services provided. Once such diagnosis code is recorded by the insurance, it becomes part of your health care record.

3. Since there are certain types of therapy that may not be covered by your insurance, such as relationship or couples therapy or group therapy, and certain modalities of therapy that might not be covered by your insurance, Self-Pay allows you to stay in control of your treatment. Self-pay allows you to also determine the length of your treatment based on your needs rather than on the basis of the allotted session benefits.

**Cancellation policy**

If you do not show up for your scheduled appointment, and you have not notified Dr. Cheshire at least 24 "business" hours in advance, you will be charged a no-show fee of $80.00.

Please, note that the reason behind this policy is to protect the provider's time, not to penalize you financially. If you are wondering why you should pay for the services you have not received, please, consider the fact that when you make an appointment with me, you are booking time with me that is no longer available for scheduling. Your session time is reserved / booked for you. I am rarely able to fill a cancelled session unless I know in advance. If you late-cancel a session or no-show, I will have to charge you for the lost time unless I am able to fill it.

**Risks and Benefits:**

Research has shown psychotherapy to be helpful for many issues. However, there is no guarantee that treatment will resolve all problems. For treatment to be effective, it may be necessary to confront or experience certain uncomfortable feelings such as sadness, guilt, anxiety, or anger, as well as to discuss unpleasant aspects of your family’s or your child’s life.

One risk of child therapy involves disagreement among parents or between parents and the therapist about the best interests of the child. If this should occur, I will work hard to listen carefully so that I can understand your perspectives and fully explain my thoughts. We can resolve such disagreements or we can agree to disagree, so long as the situation continues to support your child’s progress.

**Termination of services**

You have the right to terminate psychotherapy services at any time. Out of respect for the work and the therapy relationship, my hope is that termination would be discussed so that proper closure could take place.

**Statement of Understanding**:

By signing this agreement, you acknowledge the terms and conditions set about in this document.

I have read and understand this information and freely provide my informed consent for psychological treatment for myself or my child. I understand that contracting for psychotherapy cannot guarantee a desired outcome. I will pay Dr. Cheshire directly for her services at the time of service.

Patient Signature Date

Parent/Legal Guardian Name

Parent/Legal Guardian Signature Date

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Psychologist Signature Date