Longwood Therapy LLC

Informed Consent

Please Read Carefully

Welcome to my practice. On this document you will find helpful information about the policies of this practice and the service it provides. Equally, it provides you with information about your rights so you can consent to treatment.

I understand that:

A. I will be receiving counseling services from Carmen Gehrke, Licensed Mental Health Counselor in the state of FL, LMHC 14612, sole proprietor of Longwood Therapy, LLC located at 800 Village Square Crossing, #109. Palm Beach Gardens, FL 33410

B. Counseling can help me communicate better in my relationships, feel more connected to the important people in my life, create a sense of hope and direction, relieve feelings of frustration, depression, anxiety, among others.

C. Different counseling techniques may be utilized during the course of my treatment. Unless otherwise noted in writing, I hereby consent to the use of any counseling techniques utilized by my counselor during the course of my treatment.

D. **Records:** Longwood Therapy LLC is required by law to maintain records of each time we meet or talk on the phone. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can subpoena your records for a variety of reasons, and if this happens, I must comply. Also, if you decide to use your insurance, I will file for insurance reimbursement and I have to assign you a diagnosis. If you have any questions about this, please let me know.

E. **Confidentiality:** With very few exceptions, the information discussed during therapy sessions and all documentation (written or in any other medium) is kept private and confidential unless you expressly allow the release of information in writing.

Exceptions to this rule are:

- **if there is a court order for the therapist to appear, or to produce the client's chart;**
- **if your insurance company is involved, some limited information will be given after you sign the release of information part off the insurance form;**
- **if the therapist learns that there exists a serious threat to any person, including yourself;**
- **if there is evidence of or suspected child, dependent adult, or elder abuse.**
- **If I send my primary counselor an email containing private information. Please see the *Online Consent for more information.***

F. **Insurance:** You should also be aware that you are ultimately responsible for verifying and understanding the limits of your insurance coverage and for payment for services if your insurance plan denies coverage. Although I will assist you in your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. You may also be able to use your employer's flexible spending account (FSA), where you can apply pre-tax dollars to pay for therapy costs. Many of my clients choose to pay privately because it offers them more control and privacy. They are not constrained by what types of issues insurance will and will not cover and their mental health information, including diagnosis, is kept confidential and only shared with their express written consent.

G. **Ending Therapy:** you have the right to end therapy whenever you choose. If you do decide to exercise this option, I encourage you to talk with me about the reason for your decision, both for my own feedback as well as to discuss your progress and further recommendations or referrals. Likewise, at my discretion, I reserve the right to end our therapy work together and provide you with some appropriate referrals, for reasons including, but not limited to, failure to participate in therapy, conflicts of interest, untimely payment of fees, or my belief that I may not be the best person for your needs.

Informed Consent

I have been provided with an Informed Consent statement and have read, understand and agree to the information contained therein. I,_____, for myself and/or as parent or legal guardian of _____, indicate by my signature on this form that I consent to the evaluation/treatment process at Longwood Therapy, LLC with Carmen Gehrke, MA, LMHC. I understand that this process may include myself, my child, and/or other family members.

I also acknowledge that I have received a **Notice of Privacy Practices** and have been informed of the exceptions to confidentiality as described above.

- This consent will expire 30 days after the termination of treatment.
- I have access to the HIPAA policy.

I understand and agree to all of the above:

Signature of client (if over 14): _____
(or legal guardian)

Signature of client's guardian (if patient under 18): _____

Relationship to client if Personal Representative: _____

Date: _____