

**Dr. Darlene Powell Garlington**  
**Licensed Clinical Psychologist**

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### **Informed Consent & Agreement For Psychotherapy Services**

**Introduction.** This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise.

**Information about Your Therapist.** Whenever you wish, I will discuss my professional background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about the above, and anything else related to your therapy or other concerns.

**Fees.** The fee for service is \$ \$150.00 per 50 minute therapy session. I reserve the right to periodically adjust the fee. You will be notified of any fee adjustment in advance. Co-pays are payable at the time that services are rendered. If I do not participate in your insurance plan, full fee is payable at the time that services are rendered.

If there is a need for telephone contact, with you or a third-party, other than for scheduling purposes, you understand that you are responsible for payment of the agreed-upon fee (on a pro rata basis) for any calls lasting longer than 10 minutes.

**Appointment Scheduling and Cancellation Policies.** Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. Scheduled appointment times are reserved especially for you. If an appointment is missed, or canceled with less than 24 hours notice, you (not your insurance company) may be charged the full fee for that missed session. **Exceptions may be made if you are sick or have an unavoidable emergency.**

**Insurance.** I am a member of several insurance companies. However, co-payments are expected at the time of service. If I do not participate in your insurance company, I will provide you with a detailed bill and will be happy to assist your efforts to seek insurance reimbursement.

**Delinquent Accounts.** You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless I participate in your insurance plan. If I do not participate in your plan, and you are delinquent, you agree to pay interest at 1.5% per month. If it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due plus any collection expenses of 30-50% of any balances owing, and any attorney's fees

**Discussion of Treatment Plan.** It is my intention to provide services that will assist you in reaching your goals. Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. Sometimes more than one approach can be helpful in dealing with a certain situation. During the course of therapy, I will draw on various treatment approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches may include, but are not limited to, behavioral, cognitive, psychodynamic, system/family, developmental and/or psycho-educational techniques.

I believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with my recommendations. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks or benefits. If you could benefit from any treatment that I do not provide, I have an ethical obligation to assist you in obtaining those treatments.

**Termination of Therapy.** The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

**Professional Consultation.** Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

**Collaboration with Other Professionals.** In order to provide quality services, I often need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. You will be asked to complete a release of information authorizing these exchanges; in some cases, I may not be able to provide services without this.

**Records and Record Keeping.** I may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a request must be made in writing.

I reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I typically maintain records for ten years following termination of therapy. After ten years, your records may be destroyed in a manner that preserves your confidentiality.

**Confidentiality.** The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to, situations where you pose a threat of serious harm to yourself or someone else; cases involving suspected child, elder or dependent adult abuse; cases in which I am court-ordered to testify or produce records; or as outlined in the "Notice of Privacy Practices."

**Psychotherapist-Patient Privilege.** The information disclosed by you, as well as any records created, is subject to the psychotherapist-patient privilege. The psychotherapist-patient privilege results from the special relationship between Therapist and Patient in the eyes of the law. It is akin to the attorney-client privilege or the doctor-patient privilege. Typically, the patient is the holder of the psychotherapist-patient privilege. If I receive a subpoena for records, deposition testimony, or testimony in a court of law, I will assert the psychotherapist-patient privilege on your behalf until instructed, in writing, to do otherwise by you or your representative. You should be aware that you might be waiving the psychotherapist-patient privilege regarding your entire treatment if you make your mental or emotional state an issue in a legal proceeding. You should discuss any concerns you might have regarding the psychotherapist-patient privilege with your attorney.

**Patient Litigation.** I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with patients' attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient's legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate for such services of **\$250.00** per hour.

**E-mail and Phone Communication.** Some patients prefer to communicate about appointment times or other administrative services via e-mail. Although information stored on my computer is encrypted, e-mail transmitted through regular services is not encrypted. This means that a third party may be able to access information in an e-mail and read it, since it is transmitted over the Internet. In addition, once the e-mail is received by you, someone may be able to access your e-mail account and read it. This may include your employer if you use a work-related e-mail address. For these reasons, I discourage sending any clinical or other sensitive information via e-mail. **Please use the telephone for anything urgent or time-sensitive,** as I cannot guarantee that I will see an emergency e-mail.

Please initial the options that meet your needs. You can change this at any time by communicating to me in writing.

\_\_\_\_ I do not wish to receive any treatment-related information via e-mail.

\_\_\_\_ I understand the risks of unencrypted e-mail, and do hereby give permission to **Dr. Darlene Powell Garlington** to contact me or reply to me via unencrypted e-mail. My email address is: \_\_\_\_\_

**Therapist Availability / Emergencies.** You may leave a message for me at any time on my confidential voicemail at **516-679-0457**. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday). **Please understand that as a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, or go to the nearest emergency room.**

**Acknowledgement**

By signing below, Patient(s) acknowledge that Patient(s) have reviewed and fully understand the terms and conditions of this Agreement. Patient(s) have discussed such terms and conditions with the therapist, and have had any questions with regard to its terms and conditions answered to Patient(s)' satisfaction. Patient(s) agree to abide by the terms and conditions of this Agreement and consent to participate in psychotherapy with the Therapist. Moreover, Patient(s) agree to hold Therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

_____	_____	_____
Patient Name (please print)	Signature of Patient (or authorized representative)	Date
_____	_____	_____
Patient Name (please print)	Signature of Patient (or authorized representative)	Date

I understand that I am financially responsible for payment for all services rendered and that I will personally seek reimbursement from my insurance carrier. Any assignment and authorization in no way releases me from said responsibility and imposes no obligation on my therapist to collect money on my behalf.

_____	_____	_____
Name of Responsible Party (Please print)	Signature of Responsible Party	Date

**Consent to Treatment of Minors**

This section must be completed by the parent or legal guardian of each child who attends session. Some custody agreements require the signatures of both parents for treatment. Because of this, it is generally my policy to require the signature of both parents in any divorce situation.

**Confidentiality with Minors**

My role as a therapist is to help minors learn to communicate openly and directly with their parents, and thus, I typically involve parents in the counseling process. That said, when children are making poor and/or dangerous decisions, parents will be brought into the conversation as soon as possible, which in the case of many situations - such as suicidal ideation or attempts - is immediately.

I hereby consent to treatment of my child(ren) per the terms outlined in the above pages of this document:

Name _____ Birthdate _____	Name _____ Birthdate _____	_____
_____	_____	_____
Parent / Guardian Name (please print)	Parent / Guardian Signature	Date
_____	_____	_____
Parent / Guardian Name (please print)	Parent / Guardian Signature	Date