INSTITUTE FOR COUPLE AND FAMILY ENHANCEMENT
Ethan Harris Cohn, MS, LMFT-Associate, Independent Contract Therapist

THERAPY INFORMATION AND CONSENT TO TREATMENT

The purpose of this document is to ensure that all participants in the therapeutic process are aware of their rights and responsibilities when entering into a therapeutic relationship with me. I encourage you to ask questions about any of these topics at any point during the time that we are working together.

SAFETY IN THE THERAPEUTIC RELATIONSHIP

Research has found that the best outcomes occur in therapy when all members of a client system develop a positive relationship with their therapist. My first priority is to establish a relationship with each individual, partner, or member of a family, allowing them to feel comfortable and safe discussing and processing any situation. I seek a collaborative relationship with you in which you not only feel understood and valued, but also feel ownership in your therapeutic process. I will regularly discuss the goals of therapy to ensure that we are in agreement, and I will work to ensure that you are comfortable with any planned or suggested intervention approach. I invite you to share with me any questions, concerns, or suggestions during the course of our work together.

Also related to safety for all parties, I have a strict policy of prohibiting weapons of any kind into my office during the psychotherapy process. If you are licensed to carry a weapon or are coming to therapy from a job that requires you to be armed, please make plans to secure your weapon outside of my office.

CONFIDENTIALITY

Confidentiality means that I have a responsibility to you to safeguard information obtained during treatment. It is important that you understand that all identifying information about your assessment and treatment is kept confidential. In order to protect your confidentiality, any written, telephone, or personal inquiries about clients will not be acknowledged unless a written release of information is received from you. In order for me to coordinate your treatment with other mental health or medical professionals, I may ask you to sign a release of information to allow me to talk or correspond with other professionals who may play a role in meeting your needs (such as physicians, school officials, legal system representatives, or family members not participating in therapy with you).

It is important that you understand that the laws of the State of Texas allow exceptions to confidentiality. In certain situations, as a mental health professional, I am required by law to reveal information obtained during your sessions to other persons or agencies without your permission. Also, in these situations I am not required to inform you of my actions:

1. I am required to report suspected child abuse or neglect and to report suspected abuse of the disabled or elderly to the Texas Department of Family and Protective Services.
2. I may disclose information to law enforcement personnel in order to protect you or others when there is a probability of imminent physical injury. I may be required to disclose information to law enforcement personnel in order to protect you when there is a probability of immediate mental or emotional injury.
3. A mental health professional may be required by the court to disclose treatment information in proceedings affecting the parent-child relationship.
4. A mental health professional may disclose confidential information in proceedings brought by a client against a professional.
5. There is no confidentiality of mental health information in connection with criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
6. In the treatment of a minor client, a mental health professional may advise a parent, managing conservator or guardian of a minor with or without minor's consent, of the treatment needed by or given to the minor.
7. A health care provider, including a mental health care provider, may submit a collections claim or lawsuit against a client or former client for failure to pay for services received.

In the process of couple or family therapy, I also have unique confidentiality responsibilities when working with couples, families, and children because the family as a whole may be considered the client. When working with families, I have an obligation to more than one person. I may share information disclosed to me in individual sessions, phone conversations, or written messages with those family members who have consented to treatment. **I have a strict policy of not keeping potentially hurtful or damaging secrets from other family members who are also participating in therapy.**

Clients often prefer to communicate with me via email or text message to schedule or confirm appointments, as well as provide updates regarding their situations. While I have a duty to act with professionalism and diligence to protect your information, I cannot guarantee the confidentiality of email correspondence and text messages due to the logistics of these types of communication. I will comply with your informed requests are described in the Communications Form regarding use of texts, emails, or other communications outside of face to face communication in my office.

Another important element of confidentiality is the expectation that participating parties respect the privacy of other participating family members by refraining from sharing contents of the sessions with outside parties. **Further, recording devices of any kind (audio, video, or photographic) are not allowed in the therapy sessions without written consent of all parties attending, including your therapist.** In order to achieve your therapeutic goals, it is essential for all parties to experience trust and personal safety during therapy sessions.

THE BENEFITS AND RISKS OF PSYCHOTHERAPY

One major benefit that may be gained from participating is the resolution of concerns. Other possible benefits may be a better ability to cope with marital, family, and other interpersonal relationships, as well as a greater understanding of personal goals and values. However, seeking to resolve concerns between family members, marital partners, and other persons can also lead to discomfort as well as relationship changes that may not have been originally intended. The greatest risk of psychotherapy is that it may not by itself resolve your concerns. You may also experience discomfort such as anger, depression, or frustration during your treatment as you remember and resolve unpleasant events. I will do my best to assess progress on a week-to-week basis, and I encourage you to notify me of any changes in your condition. If a situation fails to improve or a situation deteriorates, I will provide referral to another professional for consultation or treatment.

Please know, too, that I do not provide emergency mental health services. I may not able to return your calls immediately or schedule you for immediate treatment. In the event of an emergency, you have several options. You may go to the nearest emergency room, call 911 for emergency assistance, or contact the Crisis Stabilization Unit of the Center for Health Care Services at 225-5481 (M-F, 8-5), after-hours emergency, call 531-7826. You may also call the United Way HELP Hotline by dialing 227-4357 (HELP).

FEES AND APPOINTMENTS

A standard therapy hour consists of approximately 50 minutes for the therapy session and 10 minutes to allow me to complete necessary paperwork and prepare for my next client. **My fee for a standard therapy hour is $95.** I am also able to offer reduced fees, based on client need and with approval from the ICFE Director. Please talk with me in advance of signing this agreement if you need to request a reduced rate. You may pay by cash, personal checks, and major credit cards. Additional services such as court testimony, reports, or consultation with legal professionals will be conducted for a fee of $250 per hour and will include my time as well as the involvement of my clinical supervisor. Payment for additional services is due prior to the service being rendered.

Payment for psychotherapy is due at the time services are rendered. To avoid accumulation of a balance, clients are asked to complete a Billing Agreement and provide credit card information to remain on file during the time they are active clients. Credit cards will only be billed for services provided, returned check fees, or no-show/late cancellation charges. Credit card information is securely destroyed 60 days after your last session or immediately upon your communication that you are terminating the therapeutic relationship. Clients who do not wish to

leave credit card information on file may elect to instead make a retainer payment of $285, advanced payment for 3 sessions, when scheduling the second therapy session. A $30 fee is charged for each returned check.

As an LMFT-Associate, I am not an “in-network” provider for any insurance companies; however, I will complete necessary paperwork if you elect to submit your own claim for my services to your insurance company for reimbursement. Your insurance company may or may not reimburse for my services as a LMFT-Associate providing services under supervision. Please be aware that insurance companies require a mental health diagnosis to be assigned to a single, identified client to consider psychotherapy to be medically necessary, and thus eligible for reimbursement. If my professional assessment does not determine a mental health disorder to be present or relevant to the therapy provided, I will not be able to complete a claim for your insurance company. Furthermore, I will review with you any diagnosis assigned to you to be submitted to your insurance company. Upon request, I will provide a detailed monthly invoice for services, including relevant codes your insurance company would require and complete your insurance company’s claim form. The first page of the claim form is completed at no charge; more complex forms are completed at $20/page.

Sessions are by appointment only. If you must cancel or reschedule an appointment, I require at least 24-hour notice so that I may have the opportunity to schedule another client during the appointment time. Clients who do not provide 24-hour notice that they will not be attending a scheduled session will be billed the full fee for the therapy hour.

At various points in treatment, we will discuss progress that has been made, remaining goals, and the expected time frame for treatment. Your participation in therapeutic services, though, is completely voluntary and you may stop at any time.

PROFESSIONAL SUPERVISION AND SHARED OFFICE SPACE

I am a Licensed Marriage and Family Therapist-Associate (LMFT-Associate) providing clinical services under the supervision of Jason Northrup, Ph.D., LMFT-S, LPC-S. Dr. Northrup may be contacted directly at (210) 833-4011 or northrup@icfetx.com. My status as an LMFT-Associate means that I have completed a graduate degree or its equivalent in marriage and family therapy, passed the national licensing exam, and been approved by the Texas State Board of Examiners of Marriage and Family Therapists. Upon successful completion of Board requirements, I will become a fully licensed marriage and family therapist (LMFT). To fulfill the requirements of full licensure, I meet weekly with Dr. Northrup for clinical supervision, including discussion and direction for my work with clients. As a function of Jason Northrup, Ph.D., LMFT-S, LPC-S as my clinical supervisor, Dr. Northrup will have full access to your clinical records and private health information.

I also share office space with several other therapists who are independent contractors providing services at the ICFE. Our clinical records are stored in a common area, which means that these other therapists may have access to your confidential information. Anyone affiliated with the ICFE who has access to clients’ private and confidential information is obligated by law and professional ethics to protect clients’ confidentiality.

FEEDBACK AND COMPLAINTS

I am an independent contractor providing therapeutic services at the ICFE being supervised clinically by Jason Northrup, Ph.D., LMFT-S, LPC-S and administratively by Becky Davenport, Ph.D., LMFT. Jason Northrup, Ph.D., LMFT-S, LPC-S may be contacted directly at (210) 833-4011 or northrup@icfetx.com. However, I invite and strongly encourage clients with any concerns or complaints to first talk with me directly. I will make every effort to address the issues professionally and collaboratively with you.

Additionally, clients who choose to file a complaint against me for violations of state laws and regulations or my professional ethics code should contact:

Texas State Board of Examiners of Marriage and Family Therapists
Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369 Phone: 1-800-942-5540

PLEASE READ AND INITIAL THE FOLLOWING STATEMENTS:
I/we grant my/our permission for any therapy, testing, or diagnostic evaluation may be deem necessary in individual, marital, or family psychotherapy. I/we understand the potential for emotional discomfort and relationship changes not originally intended. I/we understand that Mr. Cohn does not guarantee any particular results or outcome from the psychotherapy process.

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I/we understand and agree to the confidentiality policies stated above. These include the exceptions to confidentiality mandated by state law, as well possibility of sharing information shared in individual sessions, phone conversations, or written messages with those family members who have consented to treatment information.

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I/we understand the risks of psychotherapy as explained above. I/we understand that Mr. Cohn nor the ICFE provide emergency services and in the event of an emergency I/we agree to go to the nearest emergency room, call 9-1-1, or contact the Crisis Stabilization Unit of the Center for Health Care Services at 225-5481 (after hours 531-7826) or the United Way Help Hotline at 227-4357 (HELP).

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I/we agree to pay the fee of $95 per therapy hour. I agree to give 24-hour notice for cancelled appointments if at all possible, by calling my therapist directly at (210) 201-3767. I understand that failure to cancel or reschedule an appointment with less than 24-hour notice will result in my being charged the full fee for the appointment.

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I/we agree to pay the fee of $250 per hour for any legal involvement that is requested of Mr. Cohn and Dr. Northrup as his clinical supervisor, including but not limited to, writing reports for submission in court proceedings, communication with legal counsel, or testimony in a court case. I understand that Mr. Cohn may refuse to participate in a legal case, including providing subpoenaed medical records, without a court order.

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I/we have been provided a copy of the ICFE Privacy Policies, adopted by Mr. Cohn as an independent contractor of the ICFE, in compliance with the Health Insurance Portability and Accountability Act of 1996, and have had the opportunity to have my/our questions about the management of private health information (PHI) answered.

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Signed (Client/Minor Client Guardian) Date

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Signed (Client/Minor Client Guardian) Date

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Signed Ethan Harris Cohn, MS, LMFT-Associate Date

CONSENT FOR COMMUNICATIONS

As per the Notice of Privacy Practice, you have the right to request that I only communicate with you about your health information in a certain way or at a certain location. Please indicate where you would like to be contacted:

I prefer to be contacted by (select all that apply): O Phone O Email O Texting O Mail

I prefer to be called and/or texted at the following number:______________________________

I O DO O DO NOT want messages to be left at this number.

Please only call at these times: ____

I prefer emails to be sent to: ____

I prefer texts to be sent to: ____

I prefer mail to be sent to: ____

Specific instructions for calls, texts, emails, or other communication: ________________________

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Email, Texting, Online Platforms, and Applications

Your protected health information must be kept private and secure according to federal and state laws and professional ethics codes. Email and texting (as well as some online platforms and applications) are convenient ways to communicate for treatment purposes (such as discussing your current symptoms or concerns) and administrative purposes (such as appointment scheduling and billing). Reasonable means to protect the security and confidentiality of communications via email, texting, online platforms, and applications will be taken. **However, it is impossible to guarantee the security and confidentiality of communication via email, texting, online platforms, and applications.** Should confidential information be improperly disclosed, through no fault of mine or other ICFE clinicians, I am not liable for such disclosures.

Potential risks of communicating by email or text may include:

- Misdelivery of emails or texts to an incorrectly typed address or number.
- Email and online accounts and phones can be hacked.
- Email is easier to falsify than handwritten or signed documents.
- Backup copies of email, texts, and online platform or application data may exist even after the sender or the recipient has deleted his/her copy.
- Employers and on-line services have a right to archive and inspect emails, texts, online communications and application data transmitted through their systems.
- Information sent via emails, texts, online platforms, and applications can be intercepted, altered, forwarded, or used without authorization or detection.
- Emails, online platforms, and applications can be used to introduce viruses into computer systems.
- Emails, texts, and online platform and application data can be used as evidence in court.

All emails and texts to or from clients concerning diagnosis or treatment will be filed as part of the patient record. Since the information will be considered part of the record, other individuals authorized to access the record will also have access to those emails. Note that all email may be retained in the record of the system sending the email.

COMMUNICATION VIA EMAIL, TEXT, ONLINE PLATFORM, OR APPLICATION SHOULD NOT BE USED FOR MEDICAL EMERGENCIES.

You have the option of choosing whether to communicate with me via email, texting, online platforms and/or applications and what information you wish to communicate. **You do not have to consent to communication via email, texting, online platforms, or applications** and communication can be handled in person or via phone call or mail. You may revoke any permission at any time in writing.

By consenting to communicate through email, text, online platform or application, you also agree to the following responsibilities:

- If you send a communication that requires or invites a response, and one is not given within a reasonable time frame, it is your responsibility to notify me that the communication was not received. You cannot assume that because it was not returned that it was received.
- It is your responsibility to schedule, confirm, reschedule, or cancel appointments.
- To the extent possible you should NOT use email, texting, online platforms, or applications to make disclosures about sensitive medical information such as: mental health treatment, drug, alcohol or substance abuse, information related to AIDS and HIV, and genetic information.
- It is your responsibility to inform me of any changes to your communication preferences including changes in mailing address, phone number, email address, or online account usernames.

Email: I O DO O DO NOT consent to use **email** for

O Administrative Purposes and/or O Treatment purposes.

Other Conditions for **emailing**:__________________________________

Texting: I O DO O DO NOT consent to use **texting** for

O Administrative Purposes

Other Conditions for **texting**:____

Social Media

Requests to connect from current or former clients on social networking sites, such as Facebook, LinkedIn, Twitter, Pinterest, Google+ or other sites or apps, will not be accepted. Adding clients as friends on these sites and/or communicating via such sites is likely to compromise privacy and confidentiality. Please do not communicate with me via any social networking sites.

The ICFE has a professional Facebook page at www.Facebook.com/pages/Institute-for-Couple-and-Family-Enhancement. This account used to share general information related to mental health, parenting, romantic relationships, and couple or family therapy. If you choose to “like” our Facebook page we assume that you are making an informed decision about how this may compromise your confidentiality. The fan list on the ICFE Facebook page is public information and easily accessed by anyone on the internet. The vast majority of our followers are not clients; however, there is a small risk that you could be identified as a client simply based on your decision to follow our page.

Business Review Sites

I may have listings on Google Place, Yelp, or other similar online services which include options for users to rate their providers and add reviews. These listings are not requests for testimonials, ratings, or endorsement from you as a client. You have a right to express yourself on any site you wish. But due to confidentiality laws, I cannot respond to any review on any site whether it is positive or negative. And like blog comments and other online communications, there are privacy risks. **Please sign below to confirm your acknowledgements of the risk or text, email, and other communication tools, as well as your consent to communicate with you in the means you indicated above.**

I recognize that technology is ever-evolving and that electronic communications cannot be fully protected from unauthorized interception. Understanding the risks of electronic communication via email or texting, I have indicated my preferences and consent for communications.

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Client Signature	Date
Personal Representative Signature (if applicable)	Relationship to Client/Patient
Minor Signature (if applicable)	Date