**Catherine DeLoach Lewis, MA, LCMHC**
**Christian Therapy Services, LLC**
**4913 Chastain Avenue, Suite 8, Charlotte, NC 28217**
**704-370-0334/cathy@christiantherapyservices.com**

# INFORMED CONSENT for THERAPY and OFFICE INFORMATION

*Revised 7.31.23*

This Informed Consent for therapy along with my Professional Disclosure Statement describes my practice guidelines so you can make an informed decision about starting a professional therapeutic relationship with me.

## A. *In-Person and/or Teletherapy (Virtual)*

- **In-person**: In person sessions are preferred, especially for trauma therapy.
- **Teletherapy via Virtual Platform**: Teletherapy is offered via my virtual platform which is HIPPA compliant.

## B. *Office Hours*

- I answer calls and emails during business hours Monday – Friday.
- I see clients Tuesday – Thursday starting at 10:00am with last appointment at 5:30pm

## C. *Fees and Payment Methods*

**Fees**:

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|---|---|---|
| • Initial therapy session | 75-90 minutes | $230.00 |
| • Individual therapy session | 50-60 minutes | $150.00 |
| • Individual therapy session | 60-90 minutes | $230.00 |
| • Consultations | 75-90 minutes | $230.00 |
| • No Show/No 24-hr cancellation | | $150.00 |
| • Time needed for copies of records, plus cost of copies. | | $150.00/hour prorated |

**Payment Methods**: Payment is required at the time of the session. My HIPPA compliant payment apps will save your payment card information and I will not have access to your payment card number.

- *Credit/debit cards/HSA cards using HIPPA compliant payment third parties such as Ivy Pay.* *NOTE**: Client must use a credit/debit/HSA card in good standing funds available to cover full session fee so the charge can be completed.***
- *Insurance:* Self-pay, out-of-network provider: Since I do not file insurance for my clients, I will provide a monthly statement for you to file with your insurance company for reimbursement. This form will include a formal diagnosis we will discuss prior to your filing. I will give you the original statement for you to file with your insurance company, and I will keep a copy of this Statement in your client file. **Medicare/Medicaid: I am not a provider of Medicare or Medicaid insurance plans. If you need to use Medicare or Medicaid to pay for your services, please contact Medicaid or Medicare and ask to see your Provider List.**
- *Flex Spending Account*: I can provide a form that includes what you need to file for reimbursement.
- *Church Partnerships – please ask me for a Church Partnership Form or go to this link on my website: https://www.christiantherapyservices.com/faq-more*

## D. *Scheduling, Cancellations, No Show*

I understand unexpected events can happen and sometimes you may need to cancel and reschedule our appointment. To steward my schedule, which is my bank account, here is what I need from you:
***Consistent scheduling***: To experience consistency in our therapeutic relationship and to work toward your therapeutic goals together, scheduling sessions weekly initially and then biweekly is needed, especially as we build our therapeutic relationship. As you reach your therapeutic goals, then having sessions every 3-4 weeks for consistent growth and support will be appropriate. Email is the most efficient way to schedule and reschedule appointments.
***A 24-hour notice cancellation***: except for medical emergencies or a death of a person close to you. ($150.00 for a non-24 cancellation or No Show)
***Calendar:*** Have all your calendars (electronic, virtual, personal, business) with you at the time of our therapy session. Once we schedule, we are confirmed, so if you lose your calendar, enter the incorrect appointment, or have a work crisis, and you miss our appointment or do not give a 24-hour notice, I will need to charge you for this session.

## *E. Emergencies/After Office Hours*

I am owner and the only employee of Christian Therapy Services. I am not on call and do not provide after office hours unless you and I have made prior arrangements. So, if you are having a mental health emergency where you are experiencing suicidal or homicidal thoughts and believe you are in danger of harming yourself or someone else, please do the following:

- Dial 911
- Dial 988 Suicide and Crisis Hotline
- Go to the nearest emergency room.
- Call Atrium Healthcare **24-hour call center at 704-444-2400**
- Contact your physician and/or psychiatrist and follow their protocol.
- Charlotte-Mecklenburg County residents can call **Mobile Mental Health Crisis Team for Mecklenburg County, 704-566-3410**
- Domestic violence victims can call the 24/7 National DV Hotline at 1-800-799-7233 (SAFE) or in Mecklenburg County, Safe Alliance, Greater Charlotte Hope Line at 980-771-4673.

## *F. Inclement Weather Guidelines*

Sometimes Charlotte, NC has inclement weather that can make it difficult to safely drive to my office. When the weather is too dangerous to drive, I will contact you to offer teletherapy.

## *G. Email/Text/Social Media*

***Email*** - Because the privacy of emails cannot be guaranteed, I will not process your therapeutic concerns via email. I will, however, email handouts pertaining to our work together and schedule/reschedule our appointments unless you tell me not to email you. Please understand that confidentiality and privacy cannot be guaranteed when we use email.

***Text*** - **I do not text**. My work number is 704.370.0334 and is a land line. Here is the exception: my cell phone is for my emergency use and to process your payments for our sessions. It is password protected, I list only your first name and last name initial and do not identify you as a client in my contacts.

***Social Media*** – To maintain our professional therapeutic relationship, I do not participate in social media with my clients such as Facebook or LinkedIn.

## *H. Benefits and Risks of Therapy*

Therapy involves both risks and benefits you need to consider when making any treatment decisions. For a time, some of the risks may include:

- uncomfortable levels of sadness
- a sense of guilt or "doing something wrong"
- anxiety
- anger
- frustration
- loneliness
- helplessness or other uncomfortable emotions.
- recalling unpleasant or traumatic memories
- be mistakenly viewed by others as weak or perhaps seriously disturbed or dangerous.
- problems with people important to you
- family secrets may be revealed in your therapeutic work with me.
- conflicts in relationships may be brought into focus.

Problems may initially and temporarily worsen. Most of these risks are to be expected when people are making important changes in their lives. Finally, even with our best efforts, there is a risk that therapy and the modalities I use may not work for you.

While you consider these risks, please know also that the benefits of therapy have been shown by scientists in hundreds of well-designed research outcome studies. Some of these benefits include:

- People who are depressed may find their mood lifting.
- Others may no longer be anxious or full of rage and pain.
- In therapy, people have a chance to have a safe place to talk things out fully until their feelings are relieved, thoughts are noticed or changed, or the problems are resolved.
- Clients' relationships and coping skills may gradually improve.
- They may get more satisfaction out of social and family relationships.
- Their personal goals and values may become clearer.
- They may grow in various ways – as people, in their close relationships, in their work or education decisions and in the ability to enjoy their lives.

## *I. Confidentiality (also see Professional Disclosure Statement)*

Information about you will not be disclosed without your knowledge and consent, nor will your records be sent or shown to others without a signed release from you. There are, however, a few exceptions to your right to privacy.

- Danger to yourself and others – If you threaten to harm yourself or someone else, I am obligated by law to take actions necessary to protect any people who may be involved from physical harm. This obligation includes the duty to warn any person who may be harmed by your behavior. I will take this action only if the danger to yourself or someone else is imminent and unavoidable.
- Child, elders, disabled abuse and/or neglect – I am a mandated reporter. If I have reason to believe that a child, elder or a disabled person is being abused by you or anyone else, I am obligated by law to report this suspicion or disclose to the Department of Social Services. Abuse includes but may not be limited to severe physical punishment, sexual molestation, neglect, and abandonment.
- Litigation and legal proceedings – Our relationship is privileged which means if the court subpoenas your records, I can make a case for not releasing these records if I believe doing so may harm your mental health. With this privilege though, the court can still, with a subpoena, require me to release your records.

## *J. Legal Proceedings*

I believe it's in your best interest to keep the therapeutic relationship out of the court setting and I will resist efforts to involve me in litigation. Should I be compelled to appear in court, I will be largely unable to offer any opinions that will assist you in any imminent legal proceedings. I will also need to charge you a retainer fee, an hourly rate for my prep time and time in court and all travel and meal costs, if required to go to court. Once your therapeutic information is shared publicly in court, our counseling will most likely be unsafe and less effective for your healing and growth. By signing this Informed Consent, you agree not to ask me to appear on your behalf in any legal proceedings.

## *K. Supervision and Consultation*

I meet with other mental health professionals for case consultation, peer supervision, and accountability because I believe this is the best ethical practice for me as a sole private practice owner. Occasionally I may need to present our therapeutic work to a colleague to provide the best treatment for you. Clients are not identified by name and information shared with another mental health professional in consultation is subject to the same standards of confidentiality that apply to our therapy sessions described in the Professional Disclosure Statement and in *Section I Confidentiality* above.

## *L. Duration and End of Your Therapy*

It is difficult to determine the length of therapy. Because I work with trauma and abuse, this therapy can be long-term. But even long-term is relative. Many of my clients see improvement in 6 months to a year and then we move to maintaining these healthy changes for 3-6 months and at this point in therapy, discuss ending therapy, but these are only estimates. Sometimes the duration is shorter and sometimes it is longer. Every client's pace is different depending on her goals and having safe relationships to support her growth. I will continue therapy with you if we both believe it is not creating an unhealthy dependency on me and our work together is still making a difference in your life and helping you reach your therapeutic goals.

## *M. Ending of Therapeutic Treatment*

If you desire to stop treatment, I will provide referrals to other therapists if you ask. If you are considering discontinuing treatment, please let me know so we can work together for closure. You may also stop treatment without consulting me. I will attempt to contact you, but if you have not scheduled an appointment within 30 days of our last session, I will need to discontinue treatment and close your file.

## *N. Using and Disclosing Your Protected Health Information (PHI)*

When I examine, evaluate, diagnose, treat, or refer you, if needed, I will be collecting what the law calls "protected health information" (PHI) about you. If needed, I will use this information in my office to decide what treatment is best for you and to provide this treatment to you. If needed, I may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let me use your PHI here and to provide it to others for the purposes just described above. Your signature at the end of this Informed Consent and Office Information Form acknowledges that I've given you my Notice of Privacy Practices, which explains in more detail what your rights are and how I can use and share your information. If you do not sign this Informed Consent and Office Information Forn agreeing to my privacy practices, I cannot treat you, because I need to use your PHI to evaluate, diagnose, and treat you and if needed, collaborate your care with other providers.

In the future, I may change how I use and share your PHI, and so I will update my Notice of Privacy Practices (NPP). I will have an updated copy in my office and will give you a copy if you ask. You may also contact me,

the compliance officer, Catherine DeLoach Lewis at 704.370.0334 and cathy@christiantherapyservices.com if you wish for me to send an updated copy to you.

After you have signed this consent, you have the right to revoke it by writing to me, the compliance officer. I will then stop using or sharing your PHI, except for the PHI that has already been used or shared.

## O. *Consent to Treatment*

- I acknowledge I have read the Professional Disclosure Statement and this Informed Consent and Office Information Form.
- I acknowledge I have received the Notice of Privacy Practices (NPP) and/or have requested a copy to read later.
- I consent to actively participate in and receive therapy from Catherine DeLoach Lewis, MA, LCMHC dba Christian Therapy Services, LLC.
- I understand payment is due at the time therapy is provided and Catherine DeLoach Lewis, MA, LCMHC is considered an Out-of-Network provider with insurance plans.
- I understand the limitations of privacy and confidentiality when using technology to communicate via email, texting, phone, and engaging in teletherapy.

## *P. Acceptance of Terms*

I have read the above along with the Professional Disclosure Statement. I am informed about the policy regarding confidentiality of information Catherine DeLoach Lewis, MA, LCMHC/dba Christian Therapy Services may provide during therapy and the limits of that confidentiality. I have also received the Notice of Privacy described in this Informed Consent.

## *Q. Signatures*

***My printed name and signature below show that I understand and agree with all of these statements.***

_____ *(client's printed name)*

_____

Signature Date

**When requested, you are entitled to a copy of this Consent after you sign it.**

*The following statement is to be signed only if you decide to revoke your Consent agreed to by your signature above. If you sign this revocation, we cannot begin therapy.*

**Revocation of Consent**

I revoke my consent for your use and disclosure of my Protected Health Information (PHI), payment activities and mental health care processes.

I understand the revocation of my Consent will not affect any action taken in reliance on my consent prior to receiving my written Notice of Revocation. I also understand that I may be declined treatment from Catherine DeLoach Lewis, MA, LCMHC dba Christan Therapy Services because of my Revocation of Consent.

Signature _____ Date _____