INSIGHTFUL DIRECTION
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INFORMED CONSENT TO TREATMENT

- I will be given a clear description from my mental health provider regarding the problems, diagnosis, personal strengths/limitations and treatment interventions proposed.
- I will be given a clear recommendation for the types of treatment recommended, such as individual counseling/therapy, group counseling/therapy, family/couples counseling/therapy, addictions counseling, and/or psychiatric services. Times, dates, and session length will be discussed with my mental health provider. I voluntarily agree to undergo mental health treatment and understand that I may end treatment at any time. I understand that my mental health provider may want to discuss this with me, but that I reserve the right to stop treatment. In the cases of minors, please see addendum form – "Consent to Mental Health Treatment for Minors". Furthermore, I understand that my mental health provider may make diagnostic and treatment recommendations with which I do not agree (e.g. modality of treatment, duration of treatment, frequency of visits, etc.).
- I understand that my mental health provider cannot guarantee results (e.g., less depressed, improved marital satisfaction, etc.) of mental health services. However, there will be clearly stated reasons, goals, and objectives for continuing/discontinuing mental health treatment. This will be discussed with my mental health provider.
- I understand that there may be some risks in participating in mental health services. These may include, but are not limited to, addressing painful emotional experiences and/or feelings; being challenged or confronted on a particular issue; re-uniting with family members; or being inconvenienced due to costs/fees of counseling. I am aware that I can discuss any unforeseen risks vs. benefits with my mental health provider at any time. In the case of psychiatric care, medications, side effects, and alternative treatments will be discussed.
- I understand that I have the right to an interpreter (sign or language) if necessary.
- I understand that in the case of an emergency, services will be referred out to a 24 hour emergency "on call" system. Emergencies are generally life-threatening in nature. I have discussed with my mental health provider how to access this service.
- I understand that if I have a grievance with my mental health provider, I will first attempt to communicate this directly to him/her. In the event that the grievance is not satisfactorily resolved, I understand how to complete a "Feedback Form" (available upon request or online at InsightfulDirection.com under "Policies").
- I understand that if I choose to use a third party payer that certain services other than individual psychotherapy within an office visit will be funded privately.
- I understand that this "Informed Consent/Limits of Confidentiality Form" is not intended to be "all inclusive" of aspects of my mental health treatment. It is only intended to provide some useful information before deciding to engage in mental health treatment.

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LIMITS OF CONFIDENTIALITY

The information that you share with your Mental Health Provider is considered to be confidential. In most cases, information cannot be released to another party without your written consent. However, in certain circumstances, information can be shared legally without your permission. These circumstances include:

1. **Suicide**: if you are assessed to be a danger to yourself; cannot guarantee your physical safety against the intention of suicide; and/or have immediate suicidal plans, this information is not considered to be "confidential". Actions may be taken to ensure your safety.
2. **Homicide**: if you are assessed to be a danger to others; cannot guarantee their safety; and have immediate, specific plans to cause fatal injury/harm to another person, this information is not considered to be "confidential". Actions may be taken to protect the safety of others. The police may be notified of your intentions as well as the intended victim.
3. **Court order/subpoena**: Your Mental Health Provider(s) can be required to relinquish a copy of your written Mental Health Record to the appropriate Courts. Mental Health Providers can also be subpoenaed to testify in court without your consent.
4. **Child abuse/neglect**: Massachusetts Law requires your Mental Health Provider to report to the appropriate authorities (i.e. Child Protective Services) any suspicion or evidence of child abuse or neglect. This law also applies to past incidents of abuse or neglect.
5. **Elder abuse/neglect**: Massachusetts Law requires your Mental Health Provider to report to the appropriate authorities any suspicion or evidence of elder abuse/neglect.
6. **Laws regarding minors in mental health services**: certain information may be shared with parent/legal guardians at the discretion of the mental health provider(s).
7. **Minors can consent to treatment by a medical doctor or psychologist in the State of Massachusetts at ages 16-17 under certain circumstances.**

II. Mental Health confidential information may also be used in multiple instances within Insightful Direction without your written permission for coordinating services and delivering quality care. You may be informed if this is the case. These may include:

    1. Consultations and case conference with outside clinicians.
    2. In supervisory meetings at Insightful Direction.
    3. For billing purposes: a diagnosis is given to your insurer for reimbursement purposes

III. Other Notes on Your Privacy & Billing/Fee Information:

    1. Video and audio-taping: occasionally, Mental Health Providers will want to make an audio/video recording of your sessions. Your written permission in required. YOU HAVE THE RIGHT TO REFUSE THIS.
    2. Generally, you will be contacted by phone or mail. Internet email is discouraged unless discussed with your therapist. PLEASE NOTE: PRIVACY AND CONFIDENTIALITY OVER THE INTERNET CANNOT BE GUARANTEED.
    3. I have discussed my insurance coverage and fees with a Insightful Direction, LLC Team Member prior to this appointment. I understand that I am responsible for any co- pays or fees not covered by third parties.

4. I understand that it is the policy of Insightful Direction, LLC to charge a "no-show" fee equivalent to the full cost of that particular session in the event that I do not call to cancel an appointment with 48 hours notice. Third party insurers do not typically cover this fee. It is recommended that fees be paid at the time of service. I understand that in the event that I do not receive a regular statement from Insightful Direction, I am still responsible for the charges incurred.
5. I understand that my provider will maintain all necessary forms of confidentially during the conduction of a psychotherapy session. I understand that certain services offered can not guarantee confidentiality (workshops, group therapy, out-of-office visits e.g.). If I choose to participate in particular service, subsequent disclosure of non-guaranteed confidentiality will be issued and signed in order to participate in particular service.

I have reviewed this "Informed Consent to Treatment/Limits of Confidentiality" information with my mental health provider. I have been given the opportunity to ask questions about this information. A copy of this information is available upon request.

By signing this, I indicate my understanding of this information.

Patient Signature: _____ Date:_____

Mental Health Provider Signature: _____ Date:_____