

**Karoll Counseling, LLC**  
**744 Dulaney Valley Road, Suite 8B**  
**Towson, MD 21204**  
**Phone 443-535-3130 / Fax 410-630-3744**

INFORMED CONSENT  
PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This framework helps to create the safety to take risks and the support to become empowered to change. As a patient in psychotherapy, you have certain rights that are important for you to know about because the goal of therapy is your wellbeing. There are certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

**RISKS AND BENEFITS OF PSYCHOTHERAPY**

Psychotherapy can be of great benefit for most individuals, although there may be certain risks involved in engaging in the process of therapy that must be taken into consideration. Risks sometimes include experiencing uncomfortable feelings such as sadness, anger, guilt, shame, or frustration and can include discussing unpleasant aspects of your life. However, many discover that therapy leads to a significant reduction in your feelings of distress, improvements in relationships, and problem resolution. Ultimately, there are no guaranteed outcomes in the therapeutic process and I encourage patient involvement every step of the way concerning treatment goals, procedures, and mutual feedback during that time that you are in therapy.

**CONFIDENTIALTY**

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone what you have told me, or even that you are in therapy with me, without your permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act so as to protect your privacy, even if you do release me to share information about you. You may direct me to share information with whomever you choose, and you can change your mind and revoke that permission at any time. You may also request anyone you wish to attend a therapy session with you.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about your treatment. For example, if I believe that a child, elderly person or disabled person is being abused or has been abused, I am required to make a report to the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If a similar situation occurs in the course of our work together, I will attempt to fully discuss it with you before taking any action.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of

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information about you. Whenever I transmit information about you electronically, it will be done with special safeguards to insure confidentiality. If you elect to communicate with me by email, please be aware that email is not completely confidential. All emails are retained in the logs of your or my internet service provider. While under normal circumstances no one looks at these logs, they are available to be read by system administrators of the internet service provider. Any email I receive from you and any responses that I send to you will be kept in your treatment record.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I believe that it is important to our work together.

In other instances, I act as a member of a treatment team who is coordinating the care for your wellness. This could happen if you have medical concern affecting your emotional functioning or if you work with more than one treatment provider. In such cases, I maintain ongoing contact with professionals (e.g. primary care physicians, psychiatrists, dietitian) or other important individuals with your signed consent. Coordination of care can be essential, depending on the nature of your concerns and of our work together. With a signed release, I will contact other professionals involved in your care, on an as needed basis, to ensure optimal care. I typically contact others by phone or email, unless you object. When using email, I take extra measures to ensure your privacy; for example, I include only more basic and necessary information in emails and I do not include certain identifying information (e.g. your full name, birth date etc.), given that the internet can be seen as presenting a threat to confidentiality. You may not know about every contact that I make with other professionals, but I encourage you to ask me about my impressions and thoughts about our work together.

### **PARENTS & MINORS**

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. For children 14 and older, I request an agreement between the patient and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern, in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised. [See Adolescent Consent Form, to be signed by both adolescent and parent(s).]

### **MEETINGS**

Most evaluations in my practice will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy services are initiated, I will usually schedule appointments with a recommended duration and frequency. For example I may suggest one 50-minute session (one appointment hour of 50 minute duration) per week, or two sessions per month.

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**FEES AND FINANCIAL RESPONSIBILITY**

Therapy is a commitment, and its progress and effectiveness depend on consistent participation. I therefore understand that once a commitment to treatment is made, that payment for services is expected at the time of session unless other arrangements are made.

The following is information regarding payment and office policies. I am available to answer any questions that you may have regarding this information. My fees as of July 10, 2017 are as follows:

Initial evaluation, 80 minutes (CPT Code 90791)	\$225
Individual Psychotherapy, 50 minutes (CPT Code 90837)	\$150
Conjoint/Couples/Family, 50-80 minutes (CPT Code 90847)	\$170-\$245

These fees include reasonable time for phone calls, coordinating treatment with other treatment professionals, record keeping, and treatment plan completion. In the unusual event that more extensive written work or telephone consultation (exceeding 15 minutes) is required a fee of \$150 per hour will be charged, though I will break the hourly costs for periods of time less than one hour. I reserves the right to periodically adjust this fee. Representative will be notified of any fee adjustment in advance.

**BILLING AND PAYMENT**

I do accept cash, checks, HSA/FSA and credit cards. There is a \$30 fee for any returned checks. A current credit card number must be on file. Your credit card will only be used to pay for missed appointments, late cancellations, and unpaid balances over thirty days. All paid invoices are emailed to the cardholder at the time of the charge, if requested.

While payment is requested at the time services are rendered, iff expensive or extensive treatment is anticipated, arrangements may be made for a payment plan. The patient (or legal guardian in the case of a minor) is responsible for all fees, regardless of insurance carrier. If a person other than the patient, patient's spouse or parent has accepted financial responsibility for medical bills, a signed consent to that effect must be on file. Any remaining balance on accounts is payable within thirty days of the date when service is rendered. Finance charges could be applied at the rate of 1.5% per month to balances over thirty days old.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

**CANCELLATION POLICY**

You are responsible for coming to your session on time and at the time we have scheduled. If you are late, we will end on time. You can cancel or reschedule an appointment anytime, as long as they provide 24 hours notice. If you cancel an appointment with less than 24 hours

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notice, or fail to show up, you will be charged for the appointment, unless it is due to inclement weather, an illness or emergency.

### **INSURANCE**

I am an out of network provider for insurance. You should understand that if you choose to submit a claim to your insurance company for reimbursement for the sessions you have with me, you will be using your "out-of-network" benefits and your insurance may have certain limitations on mental health/psychotherapy benefits in the form of pre-certification, number of visits allowed or dollar amount per policy year as well as lifetime maximum benefits. You agree to accept full responsibility for charges and I am not held responsible, if you're insurance company does not cover and/or reimburse you for these visits.

For insurance reimbursement purposes, I may be asked to provide information that is confidential but necessary for this reimbursement. In accepting the terms of this contract, the patient agrees to release such information.

### **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep treatment records. You are entitled to request a copy of your records. In some cases I may prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Therefore, you and I will discuss the most appropriate way of providing you with information about your treatment. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

### **CONTACTING ME**

I am often not immediately available by telephone. I do not answer my phone when I am with patients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. Please note, I do not take calls on the weekend or holidays. If you call and do not leave a voicemail I will not return your call. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

### **EMERGENCIES/CRISIS MANAGEMENT**

Due to the structure of my practice, I am not able to provide crisis management to my patients. If it becomes apparent that you are in crisis or if safety is a concern, a crisis response plan will be formed specific to meet your needs.

If you are in crisis and I am unavailable or if it is after office hours resources include:

Crisis Text Line at <http://www.crisistextline.org>

Grassroots hotline at 410-531-6677

Maryland Crisis Hotline at 1-800-422-0009.

Callers from any state can reach a crisis counselor by calling Lifeline at 1-800-273-TALK (8255) or the National Suicide Prevention Lifeline at 1-800-273-8255.

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If it is a mental health emergency in which you feel you can not keep yourself safe, regardless of the time call 911 or go to the nearest emergency room. You may call me from there.

Not all individuals will feel comfortable with these parameters. If this is the case, we can discuss an appropriate referral to another clinician who may be better able to fit your needs.

### **LITIGATION LIMITATION**

I do not provide services relating to legal proceedings (such as divorce and custody disputes, injuries, lawsuits, etc). To be in psychotherapy with Carolyn Karoll LCSW-C, CEDS-S, you must agree that neither you, nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other legal proceeding, nor will a disclosure of psychotherapy records be requested for legal proceedings.

### **SOCIAL MEDIA POLICY**

I do not accept Friend or contact requests from current or former patients on any social networking site (Facebook, LinkedIn, etc). The exception is the Karoll Counseling Instagram account where I welcome you to follow me. Generally I believe that adding clients as Friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet.

### **TERMINATION OF THERAPY**

I reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, patient needs are outside of my scope of competence or practice, or the patient is not making adequate progress in therapy. You also have the right to terminate therapy at your discretion. Upon either party's decision to terminate therapy I will generally recommend participation in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering referrals.

### **OTHER RIGHTS**

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with patients or with former patients.

It is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you and provide clarification when possible.