Wendy Wood Moyer, LMFT
Licensed Marriage and Family Therapist
License # 15178 (AZ)
(480) 980-7926

Informed Consent for Assessment and Treatment

Hi! I look forward to working with you and helping you be the happiest and healthiest adult you can be! I know that working with a therapist is not always easy and I feel honored to be able to walk alongside you and be there to support you. Therapy is a major decision and you may have many questions. The following information is provided to new clients who are seeking therapy at Wendy Moyer, LMFT. In order to start our relationship in a healthy way, this document ensures that there are no misunderstandings about the various aspects of the psychotherapy services I provide. The purpose is to help you make an informed decision about participating in treatment. I ask you to read this information carefully and discuss with me any questions or reactions you may have.

Participation and Reactions:

Participating in therapy can result in a number of benefits, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working towards these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Intense feelings of sadness, guilt, anxiety, depression, loneliness, or helplessness may be aroused. These feelings are a normal part of the therapy process, and are usually temporary. We will work together to get through the difficult times. If you are ever concerned that our work together is not helping, let's discuss it.

Client's Rights:

1. You have the right to decide to end our psychotherapy work at any time without prejudice. If you wish, I will provide you with the names of other qualified therapists. Please note that unless otherwise contracted, no contact for 30 days will result in file closure; your file may be reopened upon agreement from both parties.
2. You have the right to ask any questions about procedures used during therapy. If you wish, I will explain my usual method of psychotherapy practices with you.
3. You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved.
4. You have the right to learn about alternative methods of treatment. I will discuss these with you during our work together

Confidentiality:

The confidentiality of all counseling interactions is protected by law. Anything you tell me is considered privileged information and will be held in confidence by me. I will not release any information to others about you unless you give me explicit permission to do so in writing, by signing a release of information form. There are certain situations in which, as a therapist, I am mandated by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required by law to inform you of my action in this regard. These circumstances include: medical emergencies; the existence of a threat of danger to self or others, reasonable suspicion of current physical/sexual, child or elder abuse; abandonment or neglect; a court order; third party billing claims requirements; receipt of properly executed consent form; and where otherwise legally required (such as to comply with worker compensation laws; or to comply with the USA Patriot Act)._____***(initials).***

EMDR (Eye Movement Desensitization and Reprocessing)-
I am a certified EMDR therapist. I am so excited to bring this to my clients because I have seen benefits in a shorter time than talk therapy. EMDR is an effective way to treat trauma. It is also an effective way to change negative experiences, perceptions and beliefs about self and others to positive ones. We store our experiences in our body and often detach from them. The bilateral stimulation helps to access both parts of the brain. It also helps with relaxation. Clients are able to access information, process negative events and store in a healthier way, creating new neuropathways in the brain that set a person up for more positive experiences in life.(_____*initials)*

Therapy Services:

1. A therapy session is normally 50 minutes in length.
2. If you are utilizing insurance, this form authorizes me, Wendy Moyer, LMFT to release your DSM V diagnosis and for it to be printed on your Health Claim Form.
3. I use a cell phone confidential voice mail system, which you can reach by dialing (480)980-7926. If I have not returned your call within 24 hours, please assume the system is not working properly and leave another message. I check messages several times throughout the day.
4. My practice does NOT have the capacity to respond immediately to counseling emergencies. You may call my personal cell (480)980-7926 and leave a message. You may also email me at wendywoodmoyer@gmail.com. True emergencies should be directed to the community emergency services (911) or the local hotlines (Empact 480-784-1500, Banner Help Line 602-254-4357, or Crisis Line 602 222-9444).
5. Email and text communication is for **non-emergencies only.** It may be used for appointment changes, referrals, and non-clinical questions. I check emails often, but if you are cancelling an appointment with less than 24 hours notice, please call the number listed above.
6. All fees and payment are discussed and covered prior to the first treatment. My fee for an hour (50 minutes) is $150.
7. If you cancel an appointment with less than 24 hours, you will be charged my hourly rate of $150.

Emails, Cell Phones, Computers and Faxes:
It is important to be aware that computers, cell phones, and email in particular are vulnerable to unauthorized access. Servers have unlimited and direct access to all emails that go through them. Additionally, my emails are not encrypted and faxes can be sent erroneously to the wrong address. My computer is equipped with firewall, virus protection, and a password. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as email, cell phone/texts, or faxes. If you communicate confidential or private information via electronic media, Wendy Moyer, LMFT, will assume you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted. (_____***initials*****)**

If you are the guardian of a minor or are a minor, please read the following:
By signing below, I give consent to Wendy Wood Moyer, LMFT to conduct therapy sessions with the minor listed below. I have also been informed of the limitations of confidentiality in terms of the treatment of a minor. I understand that special care and sensitivity may be required in releasing information to me about certain topics such as substance abuse and sexual activity. I accept Wendy Wood Moyer's judgment in regards to releasing information related to the treatment of this minor. In addition, I understand that if Wendy Wood Moyer, LMFT believes this minor is in danger of hurting him or herself, I will be notified immediately.

I am very pleased to welcome you as a client in my practice. I encourage you to ask questions about therapy at any time. Generally, the more you put into therapy, the more you will get out of it. I look forward to our time together being successful for you.

Authorization for Treatment

I, _____, authorize evaluation and treatment from Wendy Wood Moyer, LMFT, for my child/children for whom I am legally responsible. I acknowledge that I have received a copy of this informed consent agreement and the HIPAA NOTICE OF PRIVACY PRACTICES (upon request). It is agreed that either of us may discontinue treatment at any time. I also authorize the release of my/our DSM-IV diagnosis code, at my request, to be printed on the Health Claim Form in order that I submit an insurance claim for possible benefits. I agree and consent to receive counseling under these conditions.

Client: _____ Date: _____

Client: _____ Date: _____

Parent/Guardian: _____

Therapist: _____ Date: _____

NEW CLIENT INFORMATION

*please complete for each person involved in therapy

NAME: _____
STREET
ADDRESS:_____APT._____

CITY_____
STATE_____ZIP_____

PHONE_____ (Home) _____
(Work)

MAY I LEAVE A MESSAGE? ___YES ___NO
EMAIL:_____

BIRTH DATE _____ AGE_____

BIOLOGICAL PARENTS CURRENT MARITAL STATUS_____
FATHER'S NAME_____ MOTHER'S NAME_____

OTHER FAMILY MEMBERS (Name, relationship, age):
_____
_____
_____

PLEASE LIST THE NAME OF YOUR PSYCHIATRIST OR MEDICAL DOCTOR:_____
_____
_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? Yes No
If yes, please list the medications your child is taking:
_____
_____

LIST ANY DIAGNOSIS YOU HAVE _____
_____

HAVE YOU PREVIOUSLY BEEN IN ANY FORM OF COUNSELING? Yes No
If yes, please indicate name(s) of your previous therapist/counselor:
_____
_____

ARE YOU INTERESTED IN FAMILY COUNSELING? Yes No

EMERGENCY CONTACT (Contact only in an emergency)
NAME _____ RELATION:
_____
STREET ADDRESS:_____ APT._____
CITY_____
PHONE_____ (Home) _____ (Work)

Notice Of Privacy Practices For Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I have read and understand the terms of this Notice.

_____ _____

Signature Date

This office is required to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice. If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for <u>treatment</u> purposes are:

- *A provider or assistant obtains treatment information about you and records it in a health record.*
- *During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will obtain your signed authorization before sharing information with such specialists to obtain his/her input.*
- *Referral information may be forwarded to Diagnostic Testing Labs for further treatment or testing where the provider will want results of such treatment or testing reported bock to him/ her.*
- *If the provider is a specialist, your health information and progress may be reported back to your primary care provider or referring provider, upon receipt of your written authorization.*

Example of use of your health information for <u>payment</u> purposes:

- *We submit requests for payment to your health insurance company. The health insurance company requests health information from us regarding medical care given. We will provide information to them about you and the care given. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.*

Example of use of your health information for <u>health care operations</u>:

- *We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.*

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the treating provider. The information in it, however, belongs to you. You have the right to:

- *Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted as required by law:*
- *Obtain a paper copy of the Notice of Privacy Practices for Protected Health information ("Notice") by making a request at our office.*
- *Request that you be allowed to inspect and copy your billing record - you may exercise this right by delivering the request in writing to our office;*
- *Obtain an accounting of disclosures of your health information as required to be maintained by law, upon request. An accounting will not include internal uses of information for treatment, payment, operations, or disclosures made to you; and*
- *Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.*

If you want to exercise any of the above rights, please contact Wendy Moyer at (480).908.7926 or Robin Sweet in person or in writing, during normal business hours. She will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

OUR RESPONSIBILITIES

This office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or our "Notice" or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact *Wendy Moyer (480).980.7926 or Robin Sweet*. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Wendy Moyer or Robin Sweet. You may also file a complaint by mailing it to the Secretary of Health and Human Services.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. Likewise, we cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

OTHER DISCLOSURES AND USES

Notification of Family/Friends: Our office does NOT disclose protected health information or any other information to family members.

Appointment Reminders and Treatment Information: *We may contact you and/or leave a message on your telephone answering machine to provide you with appointment reminders or billing information.*

Workers Compensation: If you are seeking compensation through Workers Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers Compensation.

Abuse, Neglect & Domestic Violence: We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose *to* the institution or law enforcement official health information necessary for your health and safety or the health and safety of other individuals.

Law Enforcement: We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime in emergencies; and other appropriate situations as permitted by law.

Judicial/Administrative Proceedings: We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, discovery request or other lawful process if certain specific requirements are met. To avert a serious threat to health or safely, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

Other Uses: Any other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

The initial treatment plan [ ] Original plan [ ] Update of plan

To make efficient progress, we need specific, concrete goals. Please think about your goals in our work together. If this is couples or family therapy, please complete the goals together prior to the first session if possible.

1) What is the **first specific goal** – perhaps a very small one – that if achieved would help you feel like you are moving in the right direction? (Use clear, simple words.)

2) What is the **second specific goal** you hope to attain?

3) Therapist complete: What methods, interventions, approach will you use to achieve these goals?

To achieve these goals, what are you willing to do? Check all that apply:

- [ ] Attend therapy regularly (how often) _____
- [ ] Do homework between sessions
- [ ] Collaborate with the therapist in designing my treatment
- [ ] Try out some new behaviors my counselor might suggest

Initiated on _____/_____/_____, by: (Reviewed: ___/___/___ By:_____)

Client(s) signature(s) _____

Name(s) (PLEASE PRINT) _____

Therapist _____

Wendy Moyer, LMFT AZ15178

Discharge Date:_____

Aftercare Plan:

_____

_____

_____

_____

_____