CRAINE COUNSELING AND CONSULTING GROUP

ELLEN M. CRAINE, JD, LMSW, ACSW
Therapist, social work ethics consultant, educator, and author

31874 Northwestern Highway
Farmington Hills, Michigan 48334
Phone: 248-539-3850 fax: 248-539-9110

emcraine@crainemediation.com
www.crainemediation.com

Informed Consent and Authorization for Psychotherapy

As a Social Worker, my goal is to help you with whatever issues you want to address. Therapy is about meeting you where you are at and facilitating your progress in a treatment plan that we develop collaboratively. There are many different types of therapy and I tend to use an eclectic and systems-based approach which takes into consideration where a person has been in their life and the many factors which are feeding into where they are now. Modalities used may include: journaling, talk therapy, art, music, meditation, exercise and reading. Treatment can be longer term (6 months or more) or more short term crisis intervention and problem solving of a specific situation.

Should you choose to proceed, a positive outcome becomes our mutual responsibility. This begins with your trust in and commitment to the treatment process, and my commitment to address your questions and concerns as they come up during sessions. It also involves my commitment to you as your therapist, to help you find healing and wholeness in your thoughts, feelings, behaviors, and personal values while improving your relationship with yourself and others.

In addition to being a clinical process, therapy involves a professional arrangement, regulated by laws, ethics, your rights as a client, and my standard business practices. Before therapy can begin however, your agreement to the business practices described herein is required, by initials at six (6) specific places and your signature on page 8.

All therapy sessions with a therapist from Craine Counseling and Consulting Group will be conducted in person, face-to-face. Occasionally, a phone call may be necessary in the event of an emergency or inclement weather.

The policies and procedures of Craine Counseling and Consulting Group regarding the use of technology includes, but is not limited to the following:

1. Text messages and e-mails are strictly used to confirm or cancel an appointment;
2. Mutual consent must be given, in writing, before any session may be recorded via audio and/or video technology;
3. No therapist associated with Craine Counseling and Consulting will conduct an on-line search of you without your informed consent unless the search is necessary to for purposes of protecting you or others from serious, foreseeable, and imminent harm, or for other compelling professional reasons.
4. Confidential information will not be discussed electronically, or in person, in any setting unless privacy can be ensured.
5. Craine Counseling and Consulting Group will notify you if there any breaches of confidential information in a timely manner.

If you are now or have been meeting with another therapist and our work together would duplicate the work you are doing with that therapist, you must first terminate treatment with that therapist before I can begin providing services. Your signature and the date they are provided, along with your signature at the end of this document, is sufficient to indicate that you are not in a similar therapy elsewhere at this time.

Client Signature:_____

Date of Signature:_____

Understanding About Legal Advice

This section makes clear that under any circumstance, Ellen M. Craine, JD, LMSW, ACSW is **NOT providing legal advice** as part of the services that she provides. She may provide legal information in response to questions asked based on her prior experience as a divorce and family mediator and parenting coordinator. However, it is important for you to understand that if you need legal advice about how a particular situation impacts you legally or what the legal parameters of your situation are, you should seek legal advice from a licensed attorney. Ellen is happy to give referrals to licensed attorney should that be requested.

Client Signature: _____

Date of Signature: _____

Payment of Fees

Paying for therapy is often a very sensitive topic, and we can discuss any concerns about payment you might have as needed. This section clarifies all fees, and defines your financial responsibilities:

1. All therapy provided by Ellen M. Craine, JD, LMSW, ACSW is done so with her being considered an *out-of-network provider* for all insurance companies at this time. Therefore, it is your responsibility for you to know what coverage your insurance plan offers and to submit any information to your insurance company for any possible reimbursement from them. Ellen M. Craine will provide a form that you can use to submit to your insurance company with all the proper billing and diagnostic codes utilizing the DSM-V.

2. **All fees are considered private pay and are due in full at the end of each session beginning at your first session. A $30 returned check fee will be assessed.**

3. The current fee for therapy with Ellen M. Craine is _____ for a 60-minute session. Going over the session limit 15 minutes or more may result in additional fees being assessed for that session.

4. If both parents are responsible for fees when counseling is about, with, or for a minor child (or minor children), the fees will be shared with parent one paying _____ percent of the fee and parent two paying _____ percent of the fee.

5. With discussion, fees can be reduced once a clear determination that the financial hardship of participating in therapy would out way the benefits of participating in therapy is made.

6. Canceling appointments requires 24 hour notice by phone to avoid paying a cancellation fee of the full session rate for the missed session. If we reschedule for a date and time during the week of the cancelled session, there will be no cancellation fee charged. Please note that your cancellation fee is to be paid in full prior to the start of the next session.

7. Please note that each client is given one "freebie" for one emergency with less than 24 hours notice (illness, accident, flat tire, etc.)

8. **Craine Counseling and Consulting Group/Ellen M. Craine, JD, LMSW, ACSW** will ***NOT*** appear in court on your behalf in any matter without a court order signed by a Judge; a subpoena is not sufficient.

   Furthermore, she especially does NOT appear in Court in custody matters regardless of whether one or both parents are participating in therapy with, or on behalf of, the minor child(ren) involved. Providing any kind of recommendation in favor of one parent or another is not an option because doing so is potentially detrimental to the therapeutic process. However, if she deems it to be in the best interest of the child(ren), she will discuss your case with legal council of both parents, if necessary, with a Release of Information form signed by you in her office. There will be a consultation fee at the rate of _____ per hour for contact with legal counsel should that become necessary and may include, but not be limited to phone contact and any letters or reports written at the request of you or your attorney.

   All documentation and communication will be done within the ethical scope and requirement of confidentiality and the legal and ethical exceptions that are allowed based on Michigan law and the National Association of Social Workers Code of Ethics.

9. Telephone conversations with you, or anyone concerning your therapy, that exceed 15 minutes in time are discouraged, unless there is a crisis situation that needs immediate attention and cannot wait for an in-office session and may be billed to you at the regular session rate. This service is generally not covered by insurance.

Your initials here acknowledges that you are agreeing to the 'Payment of Fees' section stated above: _____

Date of initials: _____

CONFIDENTIALITY LIMITS AND EXCEPTIONS

1. Normally, everything we discuss will be kept confidential. Unless you provide a signed authorization, I will not speak to or correspond with anyone about you or identify you as a client.
2. Michigan law and professional ethics mandate or permit therapists to break confidentiality under certain circumstances. Some "exceptions" to confidentiality include, but are not necessarily limited to:
   a. You or your child present a danger to self or others;
   b. A child or dependant/vulnerable adult is the victim of emotion, sexual or physical abuse, neglect or unjustified mental suffering,
   c. A dependant adult or any person over the age of 65 years of age is the victim of physical abuse, emotional abuse, financial abuse, abandonment, forced isolation, or neglect.

Your initials here acknowledge that you are agreeing to "Confidentiality Limits and Exceptions" as stated above _____

Date of Initials:_____

MEDICAL, PSYCHIATRIC, AND PSYCHOLOGICAL EVALUATIONS

1. If a medical, psychiatric, and/or psychological evaluation seems warranted, we will discuss the nature of these evaluations and appropriate referrals will be provided. If the need for an evaluation by another professional is established and you do not follow these recommendations, your therapy may be necessarily suspended or terminated.

2. Certain medications that ease emotional suffering may be prescribed by a medical doctor or psychiatrist before and/or during the course of therapy. If you are already taking prescribed medications when therapy begins, or you begin medication during the course of therapy, your medication compliance will be a condition of therapy.

Your initials here acknowledge that you are agreeing to the "Medical, Psychiatric & Psychological Evaluation" conditions as stated above: _____

Date of Initials: _____

LIMITS OF COMMUNICATION

1. Every effort will be made to assist you, especially during a crisis. However, there may be times when contacting you will not be possible. Therefore, you must agree to first call 911 or go to the nearest hospital Emergency Room for assistance, any time you suspect you are in a life or death crisis (you feel suicidal or homicidal or believe you might be a danger to yourself or someone else in any way).

2. As a standard business practice, each appointment ends 60 minutes from the scheduled start of the appointment regardless of your arrival time.

3. Correspondence sent to this office is retrieved at random, and several days may go by before mail is retrieved. My office hours vary randomly from day to day, and frequently no one is available to sign for deliveries.

4. Messages are retrieved from my voice mail at 248-539-3850 several times during the day at random intervals. Calls made after 6:00 p.m. and on weekends may not be returned until the next business day.

5. If our initial contact was made by e-mail, please note that e-mail and fax machines are not confidential methods of communicating and are not used without your signed consent. Please note that clinical material will not be discussed via e-mail or text message for reasons of protecting you. E-mails will be checked only twice per day, once during the morning hours, and once during the afternoon hours at random times, depending on availability of the therapist. E-mails received in the evening hours will be returned as soon as possible during the next business day.

6. In addition, it violates your confidentiality to communicate with you via any form of on-line social networking, such as Facebook or LinkedIn.

Your initials here acknowledge that you are agreeing to the "Limits of Communications" as stated above: _____

Date of Initials: _____

RISKS ASSOCIATED WITH PSYCHOTHERAPY

Like many things in life, therapy has inherent risks. Some of these risks to you include:

1. Disruptions in your daily life that can occur because of therapeutic changes;
2. Emotional pain due to exploring personal issues and family history;
3. Experiencing emotional pain with your current relationships;
4. Although therapy begins with the hope that your life and relationship(s) will improve, there is no guarantee that this will occur.

Your initials here acknowledge that you understand that "Risks Associated with Psychotherapy" as stated above: _____Date of Initials: _____

AUTHORIZATION TO COMMENCE PSYCHOTHERAPY

Your signature below verifies that you have read (or that I have read to you) and that you understand the information contained in this authorization. It further verifies that you have had the opportunity to ask questions about anything that you have not understood up to this point. By signing this Authorization, you freely acknowledge your willingness to enter into therapy with Ellen M. Craine, JD, LMSW, ACSW utilizing the methods described in this document.

You also agree to enter into a professional business arrangement according to all business practices outlined in this Agreement. You accept total financial responsibility for payment of all fees and services as described, regardless of insurance coverage or any other "third-party" payers.

You also agree that you are releasing me of any liability that directly or indirectly results from disclosure or exchange of any information contained in this agreement. At your request, a copy of this Agreement, and any other document in your record that bears your signature will be provided.

Client Signature:_____ Today's Date: _____

Parent/Legal Guardian Signature:_____

Today's Date: _____

Pareent/Legal Guardian Signature: _____

Today's Date: _____