Bahn and Associates

3000 Professional Drive Suite D
Springfield, IL. 62703
Tel.: (217) 679-5379
Fax: (217) 679-5349

CONSENT FOR TREATMENT AND OFFICE POLICIES

Welcome to our practice. This document contains important information about my professional services and business policies. Please read it carefully, and write down any questions that you may have so that we can discuss them at our next meeting.

CONFIDENTIALITY AND ITS LIMITS

Meetings between a client and his/her psychotherapist are confidential and legally privileged, and the psychotherapist will not release information discussed to anyone without the client's written permission. However, in the following important situations a therapist is legally and ethically required to go outside the context of the therapeutic relationship and release necessary information about the client in order to preserve his/her safety or that of another:

(1) If there is an emergency situation in which the psychotherapist believes that the client may be a danger to her/himself or that s/he is gravely disabled;
(2) If the client communicates a serious threat of harm to another person or against someone to the psychotherapist;
(3) If the psychotherapist has reasonable suspicion that a child or an elder/dependent adult is being abused; or
(4) If the client's records are subpoenaed as evidence during a legal proceeding.

These situations have rarely arisen in our practice. If any such situation arises, I will attempt to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary. Additionally, disclosure of confidential information may be required by your insurance carrier in order to process a claim. In this circumstance, only the minimum amount of information will be communicated to the carrier. Please also note that if there is a breach or refusal to pay a balance, information can be given to a collection agency or small claims court.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions and concerns that you may have. The laws governing these issues are quite complex, and I am not an attorney. While I am happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

PAYMENT FOR SERVICES

Patients are expected to pay for services at the time that services are rendered, except when other arrangements have been made. If we decide that you will pay monthly then payment will be due on the last session of the month.

Bahn and Associates have chosen to practice without insurance companies governing treatment outcomes although exceptions are allowed when the client specifically asks for us to work with their

insurance company. Bahn and Associates' goal is to provide clients choice in therapist, therapy focus, treatment length, and confidentiality preservation. A receipt may be provided to submit to one's insurance company if needed and we will do as much as possible to allow choice in your treatment. For any insurance carrier; you may fill out the paperwork and submit the claim form based on being an out of network provider in most instances.

Again, legal involvement is a rare occurrence. If you become involved in litigation that requires my participation, you will be expected to pay for the professional time required, even if I am compelled to testify for the other party. Because of the complexity and difficulty of legal involvement, Bahn and Associates charges $500- per hour for preparation for, attendance, at any legal proceeding.)

CANCELLATION POLICY

Once a regular appointment time is reserved for you on mutual agreement, you are responsible for payment of all reserved sessions. Upon availability of the therapist, cancellations made with at least 24-hour notice may be rescheduled within two weeks of the cancelled session in order to avoid being billed for that session.

CONTACTING ME

My telephone is answered by a confidential voicemail at (719) 685-7869. I monitor my voice mail regularly and will make every effort to return your call within 24 hours, with the exception of weekends and holidays. When I am unavailable for an extended period of time, the name of a colleague whom you can contact in my absence will be provided to you, if necessary. If at any time you feel that you need immediate assistance or are experiencing a psychiatric emergency, contact your physician or the nearest emergency room and ask for the mental health professional on call.

PROFESSIONAL RECORDS

Both law and the standards of my profession require that I keep appropriate treatment records. You are entitled to receive a copy of the records if you ask for them. Because these are professional records, they can be misinterpreted and/ or can be upsetting to lay readers. If you wish to see your records, I recommend that you review them in my presence so we can discuss the contents.

MINORS

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is my policy to request an agreement from parents that they consent to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel that there is high risk that you will seriously harm yourself or another, in case I notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and will do the best I can to resolve any objections you may have about what I am prepared to discuss. I will discuss the matter with you if possible, and will do the best I can to resolve any objections you may have about what I am prepared to discuss.

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By signing below you certify that you have read and fully understood this consent for treatment and office policies, and voluntarily agree to undergo psychotherapy treatment with Dr. Sara Bahn. Your signature also indicates that you agree to abide by the terms of this agreement during our professional relationship; you acknowledge that it is your responsibility to pay for services rendered to you by Dr Sara Bahn, and you understand the limits of confidentiality and the office policies regarding fee payment and cancellations. By signing you certify that you have been given copies of this document and the HIPAA Notice of Privacy Practices.

Notes:

The patient has understood and freely agreed to the terms listed above.

Patient's signature **Date**

Name (printed)