Anxiety and Behavioral Health Services (ABHS)*

Psychological Practices: Beth T. McCreary, Ph.D., LLC, Joseph P. DeCola, Ph.D., LLC,
& Associated Independently Contracted Practitioners
6797 N. High Street, Suite 214
Worthington, Ohio 43085
(614) 436 – 5030

Informed Consent for Participation in Treatment

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

DOB: _____ e-mail: _____

Your therapist is: □ Beth McCreary, PhD, ABPP □ Joseph DeCola, PhD
□ Matthew Free, PhD □ Justin Braun, PhD □ Tia Piacquadio, LPCC

Please read this consent form carefully, as it describes the policies and procedures followed by your psychologist/therapist.

Types of Service Provided by Your Psychologist/Therapist:
You will be interviewed and might be asked to fill out some questionnaires to assist in determining how best to help you. Sometimes, additional psychological testing is conducted, and the reasons for this will be discussed with you if it is relevant. Treatment usually involves individual meetings, but may also include family members or significant others in some individual sessions. All treatment will be conducted only with your consent.

What You Can Expect from Treatment:
A specific, individualized treatment plan will be developed, tailored to your needs. You will often be expected to work on specific tasks outside the therapy sessions. This "homework" will be decided by you and your therapist together, and might include thinking about a particular issue, reading some relevant material, writing down a log of feelings or behaviors, or practicing a particular skill, for example. The duration of treatment is different for each person and can be difficult to estimate; your therapist will address any concerns that you have about this. If you are not feeling satisfied with your treatment for any reason, you are asked to discuss this directly with your therapist, who will work with you to uncover what might be preventing progress, will modify goals with you if appropriate, and will make a referral for you to (an)other professional(s) if necessary, and/or at your request. Sometimes people find that they have a temporary increase in their level of distress when beginning psychotherapy, because the process of working on personal issues can be difficult.

Confidentiality:
What you discuss with your therapist is kept confidential, or private, with some exceptions. The therapist can, and must, break confidentiality to protect clients (such as yourself) or others in the event of emergencies such as threats of imminent harm that a client expresses towards himself/herself or others, and upon learning of any abuse or neglect of a child, a disabled person, or an elderly person. Certain information about you may also be shared with your insurance company if you choose to have insurance billed for your care. The **Notice of Privacy Practices** provides detailed information about how private information about your healthcare is protected and under what circumstances it may be shared.

*The business name "Anxiety and Behavioral Health Services" is shared by Drs. McCreary and DeCola, each of whom maintain legally separate practices (through "limited liability companies," or LLCs), but share certain costs to more efficiently provide services to clients. Both Dr. Braun and Dr. Free are Postdoctoral Psychology Residents employed within Dr. McCreary's practice and are under her supervision; you will receive a

separate disclosure form describing this arrangement if you see one of them. Ms. Piacquadio is an Independent Contractor in Dr. McCreary's practice. In general, you will meet with only one of these therapists, and the notes about your sessions are private (seen only by your therapist, with the exception of therapists under supervision). However, the therapists may share information about you with each other for purposes of vacation & leave time coverage, should you need assistance from one of the other therapists when your treating therapist is not available for an extended period. When you have a session with a therapist, s/he is your therapist for that session and you will be billed by that therapist.

Fees for Services:
Payments for services must be made at the time of each session. Cash, checks, and credit cards are accepted. If you choose to use a credit card for payment, you are accepting the responsibility for the credit card company learning that you are receiving services from one of the therapists in this practice, and for anyone else who sees your credit card bill learning this, as well. If you use insurance to pay for treatment, you are expected to pay any co-payment at the time of service. Should your insurance company refuse to remit payment for the services, you will be held responsible for paying the amount in full. If you do not pay your bill within 30 days of the date of an invoice, 2% interest may be added per month to the balance; in addition, if you default on your bill you may be held responsible for collection charges and/or attorneys' fees. The following fees are charged for services:

Psychologists and Independently Contracted Therapists:

Initial Assessment Session = $225.	Therapy Session (16-37 minutes) = $95.
Therapy Session (38-52 minutes) = $140.	Therapy Session (≥ 53 minutes) = $190.

Postdoctoral Residents under Supervision:

Initial Assessment Session = $175.	Therapy Session (16-37 minutes) = $70.
Therapy Session (38-52 minutes) = $110.	Therapy Session (≥ 53 minutes) = $130.

Phone calls will be billed directly to you, as insurance companies typically do not cover them. There is no charge for occasional, necessary phone calls (for example, regarding scheduling) lasting under 10 minutes. Calls lasting between 10-19 minutes are billed at $50; 20-29 minutes $70; 30-39 minutes at $90; 40-50 minutes at $140. In the event that a call lasts over 50 minutes, an additional $30 is charged for each additional 10-minute period.

In addition, there are out-of-pocket fees for writing treatment summary reports (for example, if you need a report sent to a psychiatrist or physician) and for reviewing records sent from other professionals. Insurance typically will not pay for these services, although they can require considerable time and effort on the part of the therapist. The fee for writing treatment reports is $150 per hour, and for reviewing records sent from other professionals the fee is $75 per hour.

Cancellation policy:
You will be billed a flat fee of $60.00 if you miss an appointment without providing *at least 24 hours notice. Insurance will not be billed; this is charged to you.* After the third such instance, regardless of circumstances and even if you have paid the fees, your therapist reserves the right to terminate therapy and refer you elsewhere (as the lost time and income becomes significant and others who are waiting for appointments as new clients could use the appointment slots).

Technology policy:
Clinicians at ABHS do not connect with clientele on social media platforms such as Facebook, LinkedIn, or Twitter. If you send an invitation to connect with your psychologist/therapist on one of these media, the invitation will not be accepted. In addition, clinicians do not conduct therapy by email or text messaging. Email and text messaging are acceptable only for scheduling purposes, and only with the permission of your individual therapist. Please talk with your therapist about his/her preferences for contact, and whether or not that contact (with texts and emails, even for scheduling) is private and secure, as most email and texting platforms are not. ABHS typically provides in-person therapeutic services. A separate consent form must be signed when services are to be delivered via online video or telephone platforms.

Initials and Signature(s) of Consent:

Please initial each line:

_____ **1)** I have read and understand this 3-page ABHS Informed Consent form for participation in treatment. Questions have been answered to my satisfaction.

_____ **2**) The Notice of Privacy Practices form regarding how information about me may be used or disclosed has been offered to me and my questions about it have been answered to my satisfaction.

3) Please initial ***one*** of the lines below with respect to how you will pay for services:

_____ I authorize release of information about me as necessary to my insurance company for billing purposes and I authorize payment directly from my insurance company to this behavioral healthcare practice. I understand that I am responsible for payment of any balance or co-pay not covered by my insurance.

_____ I do NOT authorize release of any information about me or my treatment to an insurance company. I will be responsible to pay all fees for treatment myself.

4) Please initial ***one*** of the lines below with respect to whether or not you give permission for questionnaire data from your treatment to be used for Research, Training, and Writing purposes. Whenever possible, ABHS employs evidence-based interventions in the provision of psychotherapy. It is important to us at ABHS to be able to measure the progress of our clientele on both individual and practice-wide levels, to determine if our interventions are effective. In addition, we provide training and supervision to developing therapists in our practice, and occasionally we conduct educational seminars for other providers and for community members. We request your permission to use data from your questionnaire completion in these endeavors, and possibly in published work at some point in the future should an opportunity for this arise. Any data that would be used for these purposes could include your age in years, your identified gender, the number of sessions you attended, and relevant diagnoses, but would never include any other information about your identity.

_____ (initial) YES, I give ABHS permission to store data about my age, gender, diagnoses, number of sessions at ABHS, and questionnaire responses in its database to be used for Research, Training, and Writing. I understand that no information that could identify me as an individual would be disclosed for any of these purposes.

_____ (initial) NO, I do not consent to ABHS using my questionnaire responses or other data in research, training, or writing.

If you do not initial, or if you initial "NO," all of us at ABHS understand that we do not have your permission to use de-identified information about you in research, training, or writing. *Declining to give permission will not affect your treatment at ABHS in any way.*

Please sign and date below to indicate that you agree to the provisions stated in this document and the Notice of Privacy Practices and that you consent to treatment at ABHS:

_____ _____

Signature Date

_____ _____

Signature of Parent /Legal Guardian Date Signature of Second Parent/Guardian Date

_____

Printed names of Parents or Legal Guardians or Personal Representatives (if applicable)