Feathergill and Associates, LLC

3625 Park Place West, Suite 150
Mishawaka, IN 46545

Consent to Receive Psychological Services

Client Information

Client's Name: _____ Date: _____

Date of Birth: _____ Therapist_____

Information about Psychotherapy:

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods we may use to deal with the problems that you want to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

During our first few sessions we will discuss your needs and determine your goals for therapy. Throughout your therapy, please feel free to bring up any additional concerns as the process of therapy may reveal more to you about what you need. If you have questions about any procedures, please bring them up whenever they arise. If you are not feeling satisfied with your therapist, a referral may be made to another mental health professional.

Information about Psychological Testing:

Psychological testing typically includes a comprehensive evaluation of intellectual, academic, and/or emotional functioning. The evaluation will require direct contact, interviewing, and testing. Information may also be collected from schools, psychologists, psychiatrists, and other professionals involved in your case. Tests will be selected, administered, scored, and interpreted based upon your presenting concerns and in keeping with the rules set forth by the American Psychological Association. This means that they will be administered and scored according to the test's manual, so that valid scores will be obtained. The scores will be interpreted according to scientific findings and guidelines from the scientific and professional literature. Tests and test results will be kept in a secure place to maintain their confidentiality. Dr. Feathergill and his associates ask that you and/or your child help as much possible, by supplying full answers, making an honest effort, and working to your full potential to make sure that the findings are accurate.

Depending on the type and number of tests being administered, we may need to meet on more than one occasion for 1 ½ to 4 hours each session. An appointment is a commitment to our work. Late or cancelled appointments will delay the process so, please make every effort to attend appointments on time. If you must cancel an appointment for psychological testing, at least 72 hours in advance is requested.

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Informed Consent For Psychological Services

Please read the following statements and information carefully and sign the form af the end of the document.

- I have been provided with Information about Psychotherapy and/or Psychological Testing and have read and understand it.
- I voluntarily seek and consent to participate in the assessment and treatment that may be performed during the visit(s) with Dr. Feathergill or his Associate(s)
- I understand that no promises have been made to me as the result of this treatment or of any procedures provided by Dr. Feathergill or his Associate(s).
- I understand that my therapist or I may stop my treatment at any time. The only thing I will still be responsible for is paying for the services I have already received. If my therapist determines that treatment will end, he/she will provide an explanation and make appropriate referrals.
- I understand that information shared with Dr. Feathergill or his Associates is completely confidential with the following exceptions:

    1. If any person being treated threatens violence or harm to him/herself or to another person, my therapist will contact the appropriate people in an attempt to insure the safety of all concerned parties.
    2. Therapists are bound by law to report any suspicions of child or dependent adult abuse to the appropriate authorities.
    3. My therapist and Feathergill and Associates will comply with any and all valid court orders including those to release confidential information.
    4. If the client is a minor, the therapists, clients, and parents will discuss and agree to what information may or not be shared. If there is an emergency, it will not be deemed a breach of confidentiality for the therapist to contact parents or guardians.
    5. Your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that I can provide requested information to your carrier.
    6. The therapists at Feathergill and Associates regularly seek consultation from other psychologists or mental health professionals during which we discuss specific aspects of psychotherapy sessions in order to insure quality treatment. Information shared does not typically include any identifying information. Nevertheless, the consulting therapist is bound by the same confidentiality agreements listed in this document.
    7. In certain situations, your therapist may receive supervision from a psychologist at Feathergill and Associates in order to insure quality treatment and to meet requirements for ongoing licensure in the State of Indiana. The supervising psychologist honors the same confidentiality agreements listed in this contract.

- Information of any kind about your treatment or appointments will not be released without your prior, written permission except as outlined above or as required by law.

- I have been provided with and understand detailed information regarding my rights to confidentiality and privacy, including those provided by the Health Information Portability and Accountability Act, (HIPAA) which has been made available to me by Dr. Feathergill or his Associates.
- I understand that the therapists of Feathergill and Associates are not available by email or electronic texting for urgent clinical matters, psychotherapy, professional consultation. Any communication via text or email is agreed to at the beginning of therapy when you indicate acceptable means of communication. Text messages and email will only include non-clinical information such as scheduling issues.
- I understand that information available on the Internet through websites associated with Dr. Feathergill or his Associates does not constitute advice, diagnosis, or treatment.

Emergencies

In case of an emergency, you may call the crisis line at Memorial Epworth Hospital at (574) 647-8400, call 911, or go to the nearest hospital emergency room. The therapists of Feathergill and Associates are not routinely available by phone, and are never available by email, or text-messaging for emergencies. By signing below you agree that you will take the steps identified in this consent form in the event of an emergency.

Please note: In the event that you are experiencing suicidal thoughts, thoughts of harming yourself or others, or any thoughts or feelings that place you or others at risk, you agree to inform your therapist. Your therapist will make every effort to protect your own and others' safety. This may include any or all of the following:

- Developing a crisis response with you and other supportive people in your life so that you have easy to follow steps to take to protect yourself if your condition worsens.
- Hospitalization at an appropriate care facility with or without your consent.
- Removal of means harming self or others (such as medicine, guns, etc.).
- Contacting appropriate people or institutions, including parents, guardians, or police.

Please sign below and indicate the date that you have read and agree to the conditions outlined above concerning psychological services provided by Dr. Feathergill and/or his Associates. You may request a copy for your records.

_____ _____
Client Signature Date

_____ _____
Signature of Parent/Guardian if client is a minor Date

_____ _____
Witness/Therapist's Signature Date