

# HARMONY FAMILY COUNSELING

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## INFORMED CONSENT TO TREATMENT

- I. LIMITS OF CONFIDENTIALITY Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:
  - A. Duty to Warn and Protect- When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
  - B. Abuse of Children and Vulnerable Adults -If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
  - C. Prenatal Exposure to Controlled Substances Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
  
- II. PAYMENT AND CANCELLATION POLICY Harmony Family Counseling only accepts cash, credit, and checks.
  - A. Rates
    - Individual/couple counseling : \$150. (60 Minutes)
    - Individual/couple counseling: \$200. (90 Minutes)
    - Group counseling: \$80.00 (45 Minutes)
  - B. Cancellation- If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. A full fee is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency. A bill will be emailed directly to all

clients who do not show up for or cancel an appointment. Thank you for your consideration regarding this important matter.

- C. Nonpayment- In the event of nonpayment, Harmony Family Counseling reserves the right to terminate treatment and refer client to other services. 1. Records will not be held in the event of nonpayment. 2. Bartering is not acceptable form of payment. 3. Payment plans will be utilized in the first instance of nonpayment.

III. TREATMENT STANDARDS Counselors with Harmony Family Counseling competently utilizes evidenced based practices and strive to create a safe and welcoming environment in which therapy can occur. As such, policies are in place to offer care flexible, individualized care that maintains the standards of the profession.

#### Theoretical Orientation

- A. We use evidenced based techniques drawn from cognitive behavioral, interpersonal Process, dialectical behavioral, mindfulness based, person centered, and psychoeducational, contingency management, and motivational enhancement therapies in both group and individual settings.
- B. Phases of Therapy -The phases of therapy include assessment, treatment planning, group/individual sessions, reassessment, and termination. As part of the assessment, the counselor will gather current and historical data to in order to offer the patient a diagnosis, prognosis, and recommended treatment. During treatment planning, the counselor and patient will identify goals, objectives and target dates. As the target dates are approach, the counselor and client will together assess the client's progress and determine the course of further treatment. Termination is determined by both the client and counselor based on goals and objectives, and is viewed as an essential aspect of effective therapy.
- C. Duration-There is no standard length of treatment. Duration is based on your individual needs and is initially assessed during the treatment planning phase of therapy. It is mutually reassessed on an ongoing basis.
- D. Frequency of Session Sessions are generally once or twice weekly but is initially determined during the treatment planning phase of therapy Additional sessions can usually be scheduled when the need arises.
- E. Length of Session- In effort to be sensitive to individual needs, we offer sessions of both the standard 50 minute hour and a longer 75 minute session. Session length is initially assessed during the treatment planning phase of therapy. Please see rates.
- F. Scheduled Absences- Clients and counselor alike are expected to notify each other of vacations or other planned absences in as much advance. During counselor absences, referrals will be provided, if client so desires.
- G. Phone Calls- Brief phone calls are acceptable and require no fee. Psychotherapy in not conducted by phone so if more time is needed, an additional session should be

scheduled. If the call is urgent, client should mentioned so in the message so the counselor may return the call at the first available moment. If there is an emergency requiring immediate attention, clients are expected to call 911 or other emergency services such as the BEST team.

- H. Results- Though clients have the right to be informed of expected results, no specific promises are made regarding the results of treatment. Any number of unexpected occurrences could affect the course of treatment and should be addressed as they arise. If the mental health issues of the client are out of the counselors range of competence or outside the scope of practice, the counselor is legally required to refer, terminate or consult.
  - I. Consultation -There are times when a counselor will be required to consult with other professionals, such as when the mental health concern requires services outside the scope of competency. The confidentiality of the client is maintained at all times during a consultation.
- IV. PATIENT RIGHTS HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include:
- A. To consent to or to refuse services.
  - B. To competent, culturally sensitive services.
  - C. To receive a comprehensive and thorough psychosocial evaluation/history.
  - D. To a diagnosis and prognosis at as early a stage of therapy as possible.
  - E. To a written treatment plan that is created together with the counselor and utilized, with necessary amendments and changes, throughout the course of therapy.
  - F. To understand the costs of individual therapy sessions and projected costs of total therapy sessions upon request, before committing to a course of therapy.
  - G. To a beginning, middle and an end to therapy. If protracted or ongoing therapy is required, then the patient has the right to understand why their diagnosis might warrant this course of action.
  - H. To be informed of expected results.
  - I. To have own treatment responsibilities explained thoroughly as well as understand the therapist's responsibilities to the therapy process and to the patient. This includes the responsibility of the therapist to try a different course of treatment and/or refer patients to another therapist if therapy is ineffective after a reasonable period of time.
  - J. To complete confidentiality as provided for by state and federal laws and regulations. To request that your record be amended.

- K. To request restrictions on what information from your records is disclosed to others.  
To request an accounting disclosures of protected health information that you have neither consented to nor authorized.

- L. To determine the location to which protected information disclosures are sent.
- M. To have any complaints about policies and procedures included in official records.  
To receive information about the methods of therapy, techniques used, duration of therapy and fee structure.
- N. To know the counselor's credentials, experience, and professional background.
- O. To seek a second opinion from another therapist at any time.
- P. To request a paper copy of this Agreement.

### Informed Consent to Treatment

I have read, understand and agree to the above and give my informed consent for treatment.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Name: \_\_\_\_\_