Long Island DBT Group
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INFORMED CONSENT TO PSYCHOTHERAPY

This form documents that I,_____, give my consent to _____(the "psychotherapist" and LI DBT Group) to provide psychotherapeutic treatment to me.

While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am free to discontinue treatment at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so.

I have fully discussed with the psychotherapist what is involved in psychotherapy and I understand and agree to the policies about scheduling, fees and missed appointments. I understand that I am fully financially responsible for treatment. I understand that my therapist can issue me an insurance receipt upon request so that I may submit it for out of network insurance reimbursement if my insurance plan allows for this. I acknowledge that obtaining reimbursement is solely my responsibility as well as obtaining information from my insurance company about this benefit. I will be personally responsible for payment in full for any cancelled session if I do not give the psychotherapist at least 24 hours advance notice of the cancellation (please note that insurers don't pay for canceled sessions).

Our discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of my problems, the method of treatment, goals and length of treatment. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment.

I understand that therapy is primarily provided via in person sessions. However, therapy can also be provided via phone and HIPAA compliant videoconferencing programs when appropriate. I am aware that while there may be benefits to engaging in telehealth services, it is not the same as in person therapy. I also understand the potential risks, including but not limited to unauthorized access of my personal information that may interfere with confidentiality and technical difficulties that can effect the quality of therapy. Payment requirements that apply to in person sessions equally apply to therapy sessions conducted via telehealth methods. It is your responsibility to contact your insurance company to determine if telehealth services are reimbursable under your policy. Furthermore, the use of text messaging, email and social media communication is not a secure form of communication. If I choose to communicate in these ways, I fully agree to do so at my own risk. Urgent communication should not be done via text, email or social media. Please discuss matters that are sensitive or safety related with your therapist during in person sessions or by phone only. Lastly, each individual therapist maintains their own limits regarding the use of these forms of communication and reserves the right to contract with clients individually regarding the use of all telehealth services and electronic communication.

I understand that the psychotherapist cannot provide 24 hour emergency service. The psychotherapist has told me whom to call if an emergency arises and the psychotherapist is unavailable. In any case, I understand that in any emergency, I may call 911 or go the nearest hospital emergency room. I understand that I may call my individual therapist for phone coaching when I need help using skills. I will be oriented to the proper use of phone coaching once I sign the DBT Treatment Contract. I also understand that my individual, and not my group therapist, is responsible for phone coaching unless my individual therapist has arranged for me to contact the group therapist or another therapist on the treatment team for coaching in his/her absence.

I have received a HIPAA Notice of Privacy Practices from the psychotherapist. I understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless I give my consent. There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about those exceptions follow:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities. The psychotherapist is also mandated to report to the authorities patients who are at imminent risk of harming themselves or others for the purpose of those authorities checking to see whether such patients are owners of firearms, and if they are, or apply to be, then limiting and possibly removing their ability to possess them.

2. If I tell the psychotherapist that I intend to harm another person, the psychotherapist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or if my life or health is in any immediate danger, the psychotherapist will try to protect me, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting me.

3. If I am involved in certain court proceedings the psychotherapist may be required by law to reveal information about my treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychotherapist, civil commitment hearings, and court-related treatment.

4. If my health insurance or managed care plan will be reimbursing me or paying the psychotherapist directly, they will require that I waive confidentiality and that the psychotherapist give them information about my treatment.

5. The psychotherapist may consult with other psychotherapists about my treatment. Treatment at this practice utilizes the treatment team approach that is part of DBT. Clients receiving comprehensive DBT as well as DBT-informed or non DBT clients can have their treatment discussed as part of team meetings for clinical consultation for the purpose of providing the most effective treatment possible. Therapists may also discuss the client with other therapists within the practice, especially treatment issues that need to be shared between individual, group and family therapists as often as is needed. Further, when the psychotherapist is away or unavailable, another psychotherapist might provide therapy and coaching and so will need to have access to information about my treatment.

6. If my account with the psychotherapist becomes overdue and I do not pay the amount due or work out a payment plan, the psychotherapist will reveal a limited amount of information about my treatment in taking legal measures to be paid. This information will include my name, patient identification number, address, dates and type of treatment and the amount due.

7. If my account becomes overdue and I do not make arrangements for payment with the therapist in a timely fashion, treatment may be terminated. Therapists will make a plan for termination with the client that includes referrals for alternative treatment. A therapist is not required to continue treatment if payment for services is not made.

In all of the situations described above I understand that the psychotherapist will try to discuss the situation with me, or notify me, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

I understand that I have a right to ask the psychotherapist about the psychotherapist's training and qualifications and about where to file complaints about the psychotherapist's professional conduct.

By signing below I am indicating that I have read and understood this form and that I give my consent to treatment.

Signature:_____ Date:_____
Name (printed): _____

INFORMED CONSENT TO GROUP PSYCHOTHERAPY

I understand that the information above applies to group therapy as well as individual therapy. In addition, I consent to the additional group considerations described below:

I understand that skills training group is a required component of comprehensive DBT and is a standard component of this form of evidence based treatment. I understand I have the right to participate or decline to participate in these groups. If I am in comprehensive DBT, I understand that treatment may be terminated if I choose to decline group and/or stop participating in skills training group before I have demonstrated an ability to stop engaging in suicidal or self-harming behaviors for a sustained period of time and can demonstrate an ability to consistently use skills effectively. If I choose to participate in comprehensive, adherent DBT and I find group participation difficult, I understand that my individual therapist will work with me in using skills to make participation possible.

I understand that the psychotherapist cannot assure me that other group members will keep confidential what is said in the group therapy sessions. I assume that risk and understand that the psychotherapist cannot be held responsible for other group members revealing confidential information. There are rules, however, that are meant to protect confidentiality. These rules, which I agree to follow, are:

1. Only first names will be used at group sessions.

2. I will not discuss any information about a group member except with other group members during group therapy sessions.

3. There will be no visitors at, or recordings of, group sessions allowed.

4. For breaking any of these rules, I can be terminated from the group and/or treatment and understand I could even be subject to a lawsuit by that person.

5. In addition to these rules, I understand that there will be additional group rules that I will be oriented to prior to starting a DBT skills group that are part of this type of treatment.

By signing below I am indicating that I have read and understood this form and that I give my consent to treatment.

Signature:_____ Date:_____

Name (printed): _____