LIFE MANAGEMENT ASSOCIATES, LLC

LMA

INFORMED CONSENT, MENTAL HEALTH AND/OR THERAPY SERVICES

CLIENT NAME(S)_____ ☐ **BUTTE OFFICE** ☐ **DEER LODGE OFFICE**

Welcome to Life Management Associates, LLC. We are pleased that you selected this practice for your mental health and/or therapy services, and we're sincerely looking forward to assisting you. This document is designed to inform you about what you can expect from us, policies regarding confidentiality, emergencies, and several other details regarding your treatment here at Life Management Associates, LLC. Although providing this document is part of an ethical obligation to our profession, more importantly, it is part of our commitment to you, to keep you fully informed of every part of your therapeutic experience. Please know that your relationship with us is a collaborative one, and we welcome any questions, comments, or suggestions regarding your course of mental health and/or therapy services at any time.

BENEFITS & RISKS OF PSYCHOTHERAPY

Participation in therapy can result in many benefits to you, including improved interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits requires effort on your part. Psychotherapy requires your active involvement, honesty, and openness to change your thoughts, feelings, and/or behavior. We will ask for your feedback and views on your therapy and its progress. Sometimes more than one approach can be helpful.

During the initial evaluation or the course of therapy, remembering unpleasant events, feelings, or thoughts may result in your experiencing considerable discomfort, strong feelings, anxiety, depression, insomnia, etc. We may challenge some of your assumptions or perceptions or propose different ways of thinking about or handling situations that may cause you to feel upset, angry, or disappointed. Attempting to resolve issues that brought you into therapy may result in changes that were not originally intended. Psychotherapy may result in decisions to change behaviors, employment, substance use, schooling, housing, or relationships. Change can sometimes be quick and easy, but more often it can be gradual and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

TERMINATION AND FOLLOW-UP

Deciding when to stop our work together is meant to be a mutual process. Before we stop, we will discuss how you will know if or when to come back or whether a regularly scheduled "check-in" might work best for you. If it is not possible for you to phase out of mental health and/or therapy services, we recommend that we have closure on the mental health and/or therapy services process with at least one termination session.

Noncompliance with treatment recommendations may necessitate early termination of services. We will look at your issues with you and exercise our educated judgment about what treatment will be in your best interest.

Your responsibility is to make a good faith effort to fulfill the treatment recommendations to which you have agreed. If you have concerns or reservations about our treatment recommendations, we strongly encourage you to express them, so that we can resolve any possible differences or misunderstandings.

If, during our work together, we assess that we are not effective in helping you reach your therapeutic goals, we are obliged to discuss this with you and if appropriate, terminate treatment and give you referrals that may be of help to you. If you request it and authorize it in writing, we may talk to the psychotherapist of your choice (with your permission only) to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, we will assist you in finding someone qualified. You have the right to terminate treatment at any time. If you choose to do so, we will offer to provide you with names of other qualified professionals whose services you might prefer.

If you commit violence to, verbally or physically threaten or harass us, the office, or our families, we reserve the right to terminate your treatment unilaterally and immediately. Failure or refusal to pay for services after a reasonable time is another condition for termination of services. Please contact us to make payment arrangements any time your financial situation changes.

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DUAL RELATIONSHIPS

Mental health and/or therapy services never involve sexual, business, or any other dual relationships that could impair our objectivity, clinical judgment or therapeutic effectiveness or could be exploitive in nature. It is possible that during your treatment, we may become aware of other preexisting relationships that may affect our work together, and we will do our best to resolve these situations ethically, but this may entail our needing to stop working together, depending upon the type of conflict. Please discuss this with us if you have questions or concerns.

CONFIDENTIALITY & RECORDS

As a mental health and/or therapy services client, you have privileged communication. This means that your relationship with us as a client, all information disclosed in our sessions, and the written and electronic health records of those sessions are confidential and may not be revealed to anyone without your written permission, except where law requires disclosure. Most of the provisions explaining when the law requires disclosure are described in our Notice of Privacy Practices.

When Disclosure Is Required by Law: Disclosure is required when there is a reasonable suspicion of child, dependent adult, or elder maltreatment (abuse or neglect), when a client presents a danger to self or to others, or is gravely disabled. If a judge issues a court order for psychotherapy records and/or my testimony, I will be required by law to disclose this information.

When Disclosure May Be Required: Disclosure may be required in a legal proceeding. If you place your mental status at issue in litigation that you initiate, the defendant may have the right to obtain your psychotherapy records and/or my testimony. If you have not paid your bill for treatment for a long period of time, your name, payment record, and last known address may be sent to a collection agency or small claims court.

Couples or Relationship Therapy: In couples or relationship therapy or when different family members are seen individually, as a part of the couples or family therapy, confidentiality and privilege do not apply between the couple or among family members. Please see our attached, separate No Secrets Policy.

Emergencies: If there is an emergency during our work together in which we become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving psychiatric care, we will do whatever we can within the limits of the law to prevent you from injuring yourself or another and to ensure that you receive appropriate medical care. For this purpose, we may contact the Emergency Contact whose name and information you have provided on your Client Questionnaire.

Health Insurance and Confidentiality of Records: Your health insurance carrier may require disclosure of confidential information to process claims. Only the minimum necessary information will be communicated to your insurance carrier, including diagnosis, the date and length of our appointments, and what services were provided. Often the billing statement and your company's claim form are sufficient. Sometimes treatment summaries or progress toward goals are also required.

Confidentiality of E-mail, Voice Mail, and Fax Communication: E-mail, voice mail, and fax communication can be accessed by unauthorized people, compromising the privacy and confidentiality of such communication. LMA cannot guarantee confidentiality of e-mail, voice mail, and fax communication. If you choose to communicate confidential information with LMA via e-mail, voice mail, and fax communication, LMA will assume that you have made an informed decision and LMA will view it as your agreement to take the risk that e-mail, voice mail, and fax communication may be intercepted.

Life Management Associates, LLC utilizes TherapyNotes, a HIPAA-compliant, web-based mental health practice management program for client scheduling, electronic-medical records, and integrated billing.

600 Dewey Blvd., Suite B • Butte, MT 59701 • 302 Missouri Ave., Deer Lodge, MT 59722
Phone: 406-782-4778 • Fax: 406-782-1318

Please initial that you have read this page (for couples, two sets of initials are required) _____

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Consultation: We consult regularly with other professionals regarding our clients to provide you with the best possible service. Names or other identifying information are never mentioned; client identity remains completely anonymous and your confidentiality will be fully maintained. If, for some reason, we believe it is important to consult with another professional in-depth, and we believe identifying information about you may be shared, we will have you sign a release of information allowing us to share this information. Without such a release, we will not consult with another professional providing information that might lead another person to be able to identify you.

Release of Information: Considering all the above exclusions, upon your request and with your written consent, we may release limited information to any person/agency you specify, unless we conclude that releasing such information might be harmful to you. If we reach that conclusion, we will explain the reason for denying your request.

TECHNOLOGY STATEMENT

In our ever-changing technological society, there are several ways we could potentially communicate and/or follow each other electronically. It is of utmost importance to us that we maintain your confidentiality, respect boundaries, and ascertain that your relationship with us remains therapeutic and professional. Therefore, Life Management Associates, LLC has developed the following policies:

Cell phones: It is important for you to know that cell phones may not be completely secure and confidential. However, we realize that most people have and utilize a cell phone. Your therapist may also use a cell phone to contact you. If this is a concern for any reason, please feel free to discuss this with your therapist.

Electronic Communications (Email & Text Messages): We cannot ensure the confidentiality of any form of communication through electronic media, including text messages. You are also advised that any email sent to us via computer in a work-place environment is legally accessible by an employer. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, we will do so. While we may try to return messages in a timely manner, we cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

We are ethically and legally obligated to maintain records of each time we meet, or correspond via electronic communication such as email or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. A judge can order release of your records for a variety of reasons, and if this happens, we must comply.

Social Networking: It is our policy not to accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. You are welcome to follow Life Management Associates, LLC Facebook site. However, please do so only if you are comfortable with the public knowing your name is attached to Life Management Associates, LLC. If you have questions about this, please bring them up when we meet and we can talk more about it.

Internet Searches: While our present or potential clients might conduct online searches about the practice and/or us, we do not search my clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical wellbeing. If clients ask us to conduct such searches or review their websites or profiles and we deem that it might be helpful, we will consider it on a case by case basis and only after discussing possible impacts to our professional relationship and your privacy.

In summary, technology is constantly changing, and there are implications to all the above that we may not realize now. Please feel free to ask questions and know that we are open to any feelings or thoughts you have about these and other modalities of communication.

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MENTAL HEALTH EMERGENCIES

We are outpatient therapists, and we are set up to accommodate individuals who are reasonably safe and resourceful. We do not carry beepers, nor are we available always. If at any time this does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. Generally, we will return phone calls within 24-48 hours. If you have a mental health emergency, we urge you NOT to wait for a call back, but to do one or more of the following:

- Call 911.
- Call St. James Healthcare at (406) 723-2500 or Western Montana Mental Health's Crisis Hotline at (406) 497-9069.
- Go to your nearest emergency room.

We are requesting and consenting to the following services:

☐ Mental health evaluation, interpretation of results, & preparation of reports
☐ Counseling/Psychotherapy (individual, couples, family, or group)
☐ Substance abuse/addiction evaluation and interpretation of results
☐ Family systems evaluation, interpretation of results, & preparation of reports
☐ Child custody evaluation, interpretation of results, & preparation of reports
☐ GAL, guardian ad litem services
☐ Other services: _____

If you have any questions about any part of this document, please ask. Please sign and date below indicating that you have read and understand the contents of this form, that you agree to the policies of your relationship with us, and that you consent to the professional services of Life Management Associates, LLC.

_____ ____/____/____
Client Signature Date

_____ ____/____/____
Client/Partner Signature Date

_____ ____/____/____
Parent/Legal Guardian Signature mandatory *if client is a minor* Date

_____ ____/____/____
Therapist/Representative of Life Management Associates, LLC Date

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I acknowledge the receipt of Life Management Associates, LLC Notice of Privacy Practices. I understand that this notice may be made available to me on Life Management Associates, LLC website, but that I may always request a printed copy if I am unable to access it.

_____ ____/____/____

Client Signature Date

_____ ____/____/____

Client/Partner Signature Date

_____ ____/____/____

Parent/Legal Guardian Signature mandatory if client is a minor Date

_____ ____/____/____

Therapist/Representative of Life Management Associates, LLC Date

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NO SECRETS POLICY: (If you are participating in individual treatment, you do not need to complete this section)

This written policy is intended to inform you, the participants in therapy, that when we/Life Management Associates, LLC, and the therapist agree to treat a couple or a family, we consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, we will seek the authorization of all members of the treatment unit before we release confidential information to third parties. Also, if our records are subpoenaed, we will assert the psychotherapist-patient privilege on behalf of the patient (treatment unit). A judge may issue a court order that would override this psychotherapist-patient privilege in some cases.

During our work with a couple or a family, we may see a smaller part of the treatment unit (i.e., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that we are doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions with us, please understand that generally these sessions are confidential in the sense that we will not release any confidential information to a third party unless we are required by law to do so or unless we have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, we would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, we may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple, if we are to effectively serve the unit being treated. We will use our best judgment as to whether, when, and to what extent we will make disclosures to the treatment unit and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen, the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This “no secrets” policy is intended to allow the therapist to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individual’s interests may not be consistent with the interests of the unit being treated. For instance, information learned during an individual session may be relevant or even essential to the proper treatment of the couple or the family. If we are not free to exercise our clinical judgment regarding the need to bring this information to the family or the couple during their therapy, we might be placed in a situation where we will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

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PARTICIPATING FAMILY MEMBERS

_____		_____	
Name	*please print*	Name	*please print*
_____		_____	
Name	*please print*	Name	*please print*
_____		_____	
Name	*please print*	Name	*please print*
_____		_____	
Name	*please print*	Name	*please print*

We, the members of the couple/family/other unit being seen, acknowledge by our signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with the therapist or representative of Life Management Associates, LLC, and that we enter couple/family therapy in agreement with this policy.

_____	_____/_____/_____
Client Signature	Date
_____	_____/_____/_____
Client Signature	Date
_____	_____/_____/_____
Parent/Legal Guardian Signature *mandatory if client is a minor*	Date
_____	_____/_____/_____
Therapist/Representative of Life Management Associates, LLC	Date

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