Geffken Group, PLLC
2833 NW 41st Street, Unit 140, Gainesville, FL 32606

Informed Consent

Benefits and Risks

Counseling and Psychotherapy can be helpful in many ways, including building coping skills, improving communication and other interpersonal skills, improving relationships, changing thinking and behavior in positive ways, and other ways that can contribute to positive outcomes within your life. It can also be helpful for overcoming depression, anxiety, OCD, and other mental health issues that can be detrimental to your quality of life and that you may wish to overcome. In the end, the changes you make are up to you, and the work you put in to counseling or psychotherapy determines the benefit you receive from it.

Some risks of counseling and psychotherapy may include exploring issues within your life or experience that can bring up intense negative emotions and reactions. In some cases, working on issues such as the ones listed above may cause an intensification of the issue as we work through it, or may bring up an intense emotional reaction that may be difficult to deal with. Major life decisions may also come up within the scope of counseling or psychotherapy, and these decisions may be difficult to deal with, though they are entirely up to you to decide. If you ever experience any negative reactions to our counseling or psychotherapy work, please discuss it with your therapist. We are here to help you deal with these issues.

Records

Counselors and Psychologists are required by law to maintain records of all client interaction and client contact. These records primarily include a synopsis of the work done, observations, history of our work together, and plans for future treatment. These records can be subpoenaed in some instances, and we are required by law to comply with such a subpoena. Additionally, if you are using your insurance to pay for services we are required to file for insurance reimbursement, which requires us to provide a diagnosis. We assign you this diagnosis based on our work with you. If you have questions about record keeping or the circumstances under which records may need to be released, please let us know.

Confidentiality

All information discussed with our office or with any of our counselors or psychotherapists is kept private and confidential within our office, no matter the form of communication. There are some

legal exceptions to this confidentiality, and under such circumstances we may be forced to break confidentiality. These circumstances include:

1. You make us aware that you are a threat to yourself or someone else.
2. You make us aware or suspicious of child abuse or neglect, elder abuse or neglect, or the abuse, neglect, or exploitation of a vulnerable adult.
3. If a court orders us to appear or to release your records, as previously mentioned.
4. If you are using your health insurance to pay for therapy, some information will be released to your insurance company.

If you have any questions about confidentiality and limits to confidentiality, please ask.

Time

Counseling and psychotherapy session are typically 45-50 minutes long, though this length of time may vary according to your therapist's discretion. It is important to stick to the correctly scheduled amount of time per session in order to allow all clients to have their fully scheduled time with the therapist.

Methods of Contact

If you need to contact our office you may do so by phone or email. Our phone and voicemail at (352) 377 – 1426 are guaranteed to be secure and confidential, but we cannot guarantee that our email at geffkengroup@gmail.com is secure and confidential. As such, we request that you do not use email for any confidential communication. If we are unable to take your call for any reason please leave a voicemail and we will return the call within one business day. If you have an emergency and need immediate assistance please contact 911 or the Alachua County Crisis Center at (352) 264 – 6789.

Fees

The standard out-of-pocket fee for a session is $125. We do offer limited reduced rates intended primarily for clients without insurance. If you are using your insurance to pay for services, you are required to pay any co-pay or co-insurance at the time of service. If we accept your insurance our office will file insurance claims as a convenience to you. We do not guarantee insurance reimbursement, and if your insurance denies payment you may be responsible for the full fee.

If you are requesting a letter or any other paperwork or documentation a $50 fee will apply to the service at the discretion of the therapist to cover time spent preparing the documentation outside of session. A five-session minimum may also apply to these requests, though final agreement to provide documentation will be contingent on participation and improvement in those sessions.

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Cancellation Policy

If you have scheduled an appointment with our office it is expected that you will keep your appointment. If you need to cancel or reschedule an appointment please provide as much notice as possible, by phone/voicemail, email, or in person. If you do not provide more than 12 hours' notice of a cancellation or need to reschedule, except in the case of emergency or illness you may be charged a $25 fee at the discretion of our office. If you do not show up for a scheduled appointment and do not call to cancel you may be charged a $70 fee at the discretion of our office. Chronic cancellation or no call/no shows may lead to termination of you as a client.

Ending Therapy

Participation in counseling and psychotherapy is voluntary, and you have the right to end treatment whenever you wish. We request and recommend that if you do decide to end treatment that you discuss this decision with your therapist, in order to allow us to provide you with tools or a plan for moving forward, and to allow you and your therapist to exchange feedback on the work you have done together.

Your therapist also has the right to end treatment as well and to provide you with referrals for any reason, including but not limited to: conflicts of interest, lack of participation in therapy, chronic cancellations, no call/no shows, untimely payment of fees or lack of payment of fees, or if your therapist believes he or she is not the best person to meet your needs.

By signing below, you acknowledge that you have read and understand all of the above information, and agree to comply by it during your time as a client of the Geffken Group.

Print Client Name

Client Signature

Date:

☐ *By checking this box I certify that this typed signature holds the same legal weight as my physical signature*

Print Parent/Guardian Name (if client is under 18)

Parent/Guardian Client Signature (if client is under 18)

Date:

☐ *By checking this box I certify that this typed signature holds the same legal weight as my physical signature*

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Telemental Health Informed Consent

Please fill out if you have any interest in telemental health appointments, even if you are not participating in them at this time

I hereby consent to participate in telemental health with therapists at Geffken Group, PLLC as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, I understand my therapist will call me at my contact number on file to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. I give consent for this type of disclosure without a further release only in the case of a life-threatening emergency, and understand that only information related to the emergency situation will be disclosed in this event.

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Emergency Protocols

Your therapist needs to know your location in case of an emergency. Unless otherwise stated, you confirm that you will be located at the following address for all of your telehealth sessions:

Primary Address

Street:

Apartment/Unit #: City: State: Zip:

(If a secondary location is a frequent possibility) **Another address you may be located at during sessions**:

Secondary Address

Street:

Apartment/Unit #: City: State: Zip:

You agree to confirm which of the above addresses you are at the beginning of each session. If you are at a location not listed above you agree to let your therapist know and give them the address where you are located at the beginning of the session.

Understand that if you do not make your therapist aware of your address they will not be able to get emergency services to you in case of an emergency, and that neglecting or refusing to make your therapist aware of your location may result in you being deemed as unfit for telehealth services and necessitate a different form of treatment.

Emergency Contact

You also agree to provide us with a contact person who we may contact on your behalf in case of a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of such an emergency during session, and by signing this form you are giving your consent for this type of disclosure without a further release, and understand that only information related to the emergency situation will be disclosed.

Name: First and Last:

Phone #: Relationship to you:

Proceed to sign on the next page

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By signing below, you acknowledge that you have read and understand all of the above information related to telemental health treatment and agree to comply by it during your time as a client of the Geffken Group.

Print Client Name

Client Signature

Date:

☐ *By checking this box I certify that this typed signature holds the same legal weight as my physical signature*

Print Parent/Guardian Name (if client is under 18)

Parent/Guardian Client Signature (if client is under 18)

Date:

☐ *By checking this box I certify that this typed signature holds the same legal weight as my physical signature*

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Updated Client Paperwork

Client Information

Full Name:

Age: DOB M/D/Y: Gender: Race/Ethnicity:

Address

Street:

Apartment/Unit #: City: State: Zip:

Preferred Phone #: *Can we text you on this phone:*

Type: ☐ Home ☐ Cell ☐ Work *Is it okay to identify our practice in messages to this phone:*

Alternate Phone #: **Email:**

Type: ☐ Home ☐ Cell ☐ Work

Parent/Guardian Information (If client is under 18)

Full Name:

Preferred Phone #: *Can we text you on this phone:*

Type: ☐ Home ☐ Cell ☐ Work *Is it okay to identify our practice in messages to this phone:*

Alternate Phone #: **Email:**

Type: ☐ Home ☐ Cell ☐ Work

Address - check if ☐ *address same as client*

Street:

Apartment/Unit #: City: State: Zip:

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Insurance Information

Insured's Information *(check one →)* ☐ ***same as client*** ☐ ***same as parent/guardian*** or fill in below

Full Name:

Age: DOB M/D/Y: Gender: Relation to Client:

Address - check if ☐ *address same as client*

Street:

Apartment/Unit #: City: State: Zip:

Insurance Information

Insurance Company:

Member ID #: Contact Phone (for Providers):

Secondary Insurance Information

Insurance Company:

Member ID #: Contact Phone (for Providers):

By signing below, I certify that Geffken Group, PLLC has permission to release required information to my insurance company in order for them to submit claims on my behalf. I understand that I may request information about what has been released at any time and can revoke this permission in writing at any time for future dates of service. I understand that information released typically includes demographic information, diagnosis, and date of service, but may include more detailed records of appointments (session notes) when requested by my insurance company.

Print Client Name *(Parent/Guardian Insured if Client Under 18)*

Client Signature *(Parent/Guardian Insured if Client Under 18)*

Date:

☐ *By checking this box I certify that this typed signature holds the same legal weight as my physical signature*

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Emergency Contact

For your safety in case of emergency, we ask you to provide us with an emergency contact in case of a life-threatening emergency at our office. This person will only be contacted in the event of such an emergency while at our office, and by signing this form you are giving your consent for this type of disclosure without a further release, and understand that only information related to the emergency situation will be disclosed.

Name: First and Last:

Phone #: Relationship to you:

Consent for Treatment

By Signing Below, I confirm that all of the information I have provided above is correct to the best of my knowledge. By signing below, I also agree to receive treatment from the Geffken Group, PLLC and any of the counselor, psychologists, or practitioners who are part of the Geffken Group, PLLC. I confirm that I have been provided with a copy of the Informed Consent and have reviewed it, and confirm that I understand it and agree to abide by the terms listed within it.

Print Client Name

Client Signature

Date:

☐ *By checking this box I certify that this typed signature holds the same legal weight as my physical signature*

Print Parent/Guardian Name (if client is under 18)

Parent/Guardian Client Signature (if client is under 18)

Date:

☐ *By checking this box I certify that this typed signature holds the same legal weight as my physical signature*