SAINT LUKE INSTITUTE

8901 New Hampshire Avenue ▪ Silver Spring, MD 20903 ▪ 301-445-7970 ▪ Fax: 301-422-5400 ▪ www.sli.org

Caritas Counseling Center
Consent to Treatment

Please read this form prior to your first session. You'll have the opportunity to discuss it with your therapist and will sign it at your first session.

NAME: _____ SLI#:_____

STARTING THERAPY

Thank you for choosing the Caritas Counseling Center, the outpatient program of Saint Luke Institute, as your mental health provider.

Psychotherapy is a process of growth which calls for honesty and openness in an emotionally safe atmosphere based on trust and understanding. There are some basic "ground rules" that will contribute to the enhancement of the therapeutic process. Our mutual understanding and adherence to these ground rules and administrative policies will aid in the most effective use of our time and efforts, and will reduce the possibility of future misunderstandings that might interfere with the therapeutic process.

CONFIDENTIALITY

All treatment is confidential and we need your written permission if you wish your therapist to discuss your treatment with anyone else, including your insurance company. Your identity and other distinguishing facts about your life will be known to the staff members of Saint Luke Institute who are directly involved with your therapy. We work as a team and your therapist may consult about aspects of your treatment with clinical staff at Saint Luke Institute. Saint Luke Institute, however, will take all possible precautions to ensure your privacy and confidentiality. Confidentiality will be protected at all times in accordance with the Annotated Code in the State of Maryland (as applicable).

IT IS REQUIRED BY LAW THAT SOME SITUATIONS MUST BE REPORTED, EVEN WITHOUT THE PERMISSION OF THE CLIENT. These activities include but are not limited to suspected past or present neglect of a child, or physical and/or sexual child abuse and/or suspected past or present abuse, neglect, self-neglect and/or exploitation of a vulnerable adult. If we believe that you present a danger to your own life or safety or to others, we reserve the right to take appropriate action to protect you or any other person. We may also be required to discuss aspects of your treatment without your permission if we are court-ordered to do so.

_____ _____

Client Initials Date Therapist Initials Date

Just as we respect your right to confidentiality, we need your commitment to respect the confidentiality of other clients by not revealing their presence at Caritas Counseling Center or Saint Luke Institute and not disclosing the content of any discussions in group sessions. This commitment is subject to obeying any court order. You will notify Saint Luke Institute if anybody seeks this information from you.

PAYMENT POLICY

Payment is due at the time services are rendered unless an alternative plan has been discussed with your therapist. Caritas Counseling Center is are not on insurance panels. However, we will assist you by submitting your insurance forms, so that your insurance company might reimburse you. Saint Luke Institute bills monthly. Included will be a list of services provided and appropriate codes. We recommend that you check with your insurance company regarding what services the company will cover, since insurance often does not reimburse what clients expect.

APPOINTMENTS AND CANCELLATIONS

Your appointment time is reserved for you. You will be billed for the total charge of any sessions that you miss unless you have given prior notice at least 24 hours in advance of the appointment time. If you miss three consecutive sessions without notice or contact, you will be informed by mail that your appointment time will no longer be held for you. You will need to contact your therapist to arrange a new appointment time should you wish to continue treatment. Most insurance companies will not reimburse you for missed appointments

ENDING THERAPY

Our goal is to provide quality service in the briefest period of time that is necessary for you to derive benefit from the therapy. You have the right to withdraw from treatment for any reason at any point. Since termination is an important part of the therapeutic process we ask that you not precipitously decide to end therapy. Ideally, when it is nearing the time to end therapy (within three months) you and your therapist will discuss this and set up a termination plan. In the event that you terminate therapy but wish to resume at a later date, you may not be able to meet with the same therapist.

Termination from therapy will result in the termination of any psychiatric services you are receiving through Saint Luke Institute since receiving those services requires dual enrollment in psychotherapy with a Saint Luke Institute clinician.

Four missed appointments without notification or contact for thirty days will result in termination of therapy. Your therapist will try to contact you once to resume services before sending a termination letter.

_____ _____

Client Initials Date Therapist Initials Date

EMERGENCIES

In the event of an emergency, please go to the nearest emergency room or call 911. For less urgent matters, please leave a message on your therapist's voicemail. If you need to talk to your therapist outside of business hours call Saint Luke Institute's Clinic at 301-422-5475.

WARRANTY

We cannot guarantee a "cure" for whatever brings you to seek therapy but we can accord to you such treatment as Saint Luke Institute normally gives other clients under similar circumstances. We are a professional, highly competent, and dedicated staff who will do our best to serve you well.

If you do not understand any part of this agreement, please request an explanation.

CONSENT TO TREATMENT

I have read this consent to treatment form and have had it explained orally to me if I required and requested it. All of my questions have been answered, and I freely and voluntarily choose to participate in treatment. This Consent to Treatment agreement will be valid until my discharge as an Outpatient.

I understand that I am free to discontinue therapy at any time. If I choose to withdraw my consent and to discontinue therapy, I hereby release the attending physician, the staff, and Saint Luke Institute from all responsibility and defend them from all claims of liability for any ill effects which may result from said withdrawal of consent and discontinuation of participation in therapy.

_____ _____
CLIENT SIGNATURE Date

_____ _____
THERAPIST SIGNATURE Date

_____
Expiration Date: Day of Discharge

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