Debra Dalby, LCSW
19415 Deerfield Ave #307
Lansdowne, Virginia 20176

Informed Consent

Welcome! Before beginning therapy, it is important to review this Consent Form regarding the therapy services and policies of this therapist. Please read through the document thoroughly. Debra Dalby, (herein referred to as "This Therapist"), will answer any questions you (the Client) may have regarding the information or the process of therapy before we begin. Signing this document will confirm the agreement between us.

Services offered

This Therapist provides services for adults and couples seeking treatment for depression, anxiety, PTSD and marital distress. This Therapist employs various techniques, including cognitive behavioral, emotionally focused treatment, Internal Family Systems and Sensory Motor Psychotherapy that are based on attachment theory, gestalt, and mindfulness. You and This Therapist will collaborate to assess your current situation and develop a treatment plan. If at any time this treatment plan is not effective and modifications are not satisfactory, either party may terminate treatment. If you choose to terminate, you are strongly encouraged to arrange for a final session with this Therapist to provide closure and receive appropriate referrals at your request.

Please be advised that the therapy process can be an emotional and distressing experience at times. Additionally, you may sometimes experience your symptoms as worse than before you began. This is a normal part of the process. However, should this occur, it is the responsibility of the client to notify This Therapist in order for these issues to be addressed during the sessions. Additionally, This Therapist may make treatment suggestions. You are not required or obligated to follow those suggestions. If at any time a suggested treatment option is disagreeable to you, you do not have to follow the suggestion.

While therapy often leads to improvement of symptoms, there is no guarantee. However, effectiveness requires active participation of you, the client, in this process. This may require a commitment by you of time, money and energy. Weekly sessions are recommended. Additionally, it is important that you feel comfortable working with This Therapist. If at any time you determine that this alliance is not a "good fit" for you, then please notify This Therapist to address your concerns and explore options.

Appointments, Fees and Cancellations

The initial session is approximately 60 minutes in duration at the rate of $150. Standard sessions are 50-60 minutes in duration at the rate of $140 per session. If an extended session is required and agreed upon by all parties, then the payment will be prorated based on the standard session fee. There is a **48 hour cancellation policy**. If an appointment is canceled by the client within 48 hours and the session cannot be rescheduled for another time during that week, then a full session fee will be assessed at This Therapist's discretion. Every calendar quarter, there is allowed one (1) late cancellation at no charge. No fees will be assessed if cancellation is prior to the 48 hours. All "no show" appointments will be charged a session fee.

Payment

Unless agreed upon in advance, payment is expected by the end of the session in the form of a check, cash or IVY Pay, which is HIPPA compliant. If payments have not been made on a timely basis, or the outstanding balance is 30 days or longer, then This Therapist reserves the right to terminate therapy. Outstanding balances will be sent to a collection agency in order to collect payment and the cost of collection will be included in the claim.

This Therapist banks at Truist Bank. Be aware confidentiality may be potentially compromised when a payment is made using a check.

Insurance

This Therapist does not participate on any Insurance Panel. All sessions are considered a" fee for service". If you are submitting for out of network insurance, please request a receipt from This Therapist. This Therapist cannot guarantee any amount of financial reimbursement from your insurance company. By requesting a receipt for services rendered, be advised your insurance company may require additional information from This Therapist. In this case, by signing this form, you are

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authorizing release of necessary information to the insurance carrier billed for those services in order to determine benefits to which you are entitled. Be advised that you are responsible for charges not paid for by your insurance carrier.

If you plan to access your insurance to cover the cost of these sessions, you are encouraged to contact your insurance company to review your benefits for mental health coverage. Your plan may have restrictions or limitations on the number of sessions and amounts covered. This information may be important in determining how these limits may affect your treatment plan.

Please be advised that in order to submit for Insurance, you will be assigned a clinical diagnosis. This information will become part of the Insurance files. Insurance Companies are bound by confidentiality; however, This Therapist does not have control over how the Insurance Company handles this information. If you have questions or concerns about this, please feel free to discuss these issues with This Therapist.

Termination

You have a right to terminate sessions at any time. A final termination session is strongly encouraged in order to review your progress and/or provide appropriate referrals.

If at any time, you feel the treatment is not effective, please notify This Therapist before terminating in order to address the therapeutic issues.

If you have not made an appointment within 30 days from your last appointment, then treatment with This Therapist will be considered terminated and case closed. You will be responsible for any outstanding fees incurred to This Therapist for services provided.

In the case of Couples Therapy: if one party decides to terminate counseling, than Couples Therapy will be terminated. The party should notify This Therapist in writing (e-mail acceptable) and include the other partner in the correspondence. Again, a final session is encouraged to address outstanding issues.

Confidentiality

Please be advised that communications with This therapist is considered confidential and information will not be revealed without prior written consent from you; however, there are a few exceptions and/or limitations.
This Therapist will have to break confidentiality if:
1) Information from you causes this therapist to believe you are a danger to yourself (imminent self-harm) or to another (homicide). This is required by law.
2) Information from you reveals you have committed child or elder abuse and/or This Therapist believes that this has occurred. This is required by law.
3) There is a court order given to This Therapist, or This Therapist is required by law to release records/information.
4) You direct This Therapist to release your records by signing a release of information and, in the case of couples, both parties have signed a release for the purpose of comprehensive care (primary physicians, school counselor, etc)
5) Collection proceedings become necessary. In this case, only basic information such as dates and times of sessions will be revealed.

Periodically, This Therapist participates in peer consultation and supervision in order to enhance professional skills and obtain required continuing education units for licensure. During such times, This Therapist will not use client's identifying information.

LASTLY, This therapist will not keep secrets during couples work. If one party reveals a secret to This Therapist, which is relevant to the couple relationship, you will be encouraged to reveal it to your partner during a couple session. If you, the partner, do not wish to reveal the secret, or cannot do so within two couple sessions, then This Therapist reserves the right to terminate treatment. At that time referrals will be provided.

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Communication

This Therapist uses phone contact and email for setting up appointment times. When leaving a message for This Therapist, PLEASE be sure to include your name and phone number. This Therapist will attempt to return calls and emails on a timely basis during the week. In the case of couples work, This Therapist requires that emails and text messages include both spouses/ partners in the communication with This Therapist.

PLEASE NOTE that **email, phone and text messages** are NOT considered HIPPA compliant (aka secure) modes of communication; therefore, information in these messages are not considered confidential. Please be aware of this when leaving messages and do not include detailed information about your treatment. Likewise, This therapist will use email, phone and text messages for logistical purposes such as scheduling appointments or providing resources for you to explore. However, upon your request or agreement, This Therapist may use email or text to send links related to your treatment, provide billing information or receipts.

You have the right to opt out of these options. Please be sure to discuss with This Therapist other options of communication.

Emergency procedure

This Therapist does not provide emergency services. If you have an emergency, please call 911 or go to the nearest Emergency Room. Feel free to call This Therapist at any time to leave a message regarding your needs; however, know that this therapist may not be able to return your call immediately.

During extended absences, This Therapist may provide an "on call" licensed Therapist for you to contact, if necessary.

Records

Your records will be kept for a period of 7 years from the date of your last session. After that time, any and all session records will be destroyed. In the case of minor children, records will be kept 7 years after their 18th birthday.

You are entitled to a copy of your records or a prepared summary of your treatment. In the event you wish to obtain a copy of your records, please be advised that these are professional records and may be misinterpreted and/or upsetting. For that reason, This Therapist may encourage you to review them with This Therapist in order to discuss the content and meaning.

Court and related fees

This Therapist will not appear in court unless subpoenaed and will notify you of any such order. Should you believe This Therapist is being considered for use in a court case, please advise This Therapist and allow for discussion of such during a session.

Release of Information and waivers of confidentiality will be required by all parties prior to any court appearance or release of records. Should This Therapist receive a subpoena for records, This Therapist will notify you and encourage you to speak with an attorney to discuss and/or submit a motion to quash. If This Therapist believes that the submission of records may be harmful to you, This Therapist may submit a motion to quash if your attorney declines to do so.

This Therapist reserves the right to charge you, the client, reasonable fees for time (including court appearance, travel) and preparation. The rate for these services will be charged at This Therapists hourly rate of $140 per hour.

Teletherapy

This Therapist offers Teletherapy as a venue for psychotherapy treatment. Teletherapy can be utilized during times when meeting face-to-face is not possible. You have the option to request or decline this form of therapy.

By consenting to Teletherapy, you understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, and education using interactive audio, video, and/or data communications.

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You have the following rights with respect to teletherapy:

(1) The right to withhold or withdraw consent at any time without affecting your right to future care or treatment.
(2) The laws that protect the confidentiality of your medical information also apply to telemedicine. As such, you understand that the information you disclose during the course of your therapy is confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where you make your mental or emotional state an issue in a legal proceeding.
(3) The dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your written consent.
(4) You understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of This Therapist, that the transmission could be disrupted or distorted by technical failures;
(5) Telemedicine services and care may not be the same as face-to-face service.
(6) If This Therapist believes you would be better served by another form of psychotherapeutic service (e.g. face-to-face service), you will be referred to a psychotherapist in your area who can provide such service.

Additionally, you understand that there are potential risks and benefits associated with any form of psychotherapy or Teletherapy and that results in therapy cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to:

- finding a greater ability to express thoughts and emotions
- transportation and travel difficulties are avoided
- time constraints are minimized
- Continuity of Care

For all forms of psychotherapy, you understand that reasonable and appropriate effort is always made to protect the confidentiality, integrity and availability of your PHI (protected health information).

This Therapist primarily uses Doxy.me for Telehealth, a HIPPA approved platform. However, at times it becomes necessary to use Zoom or the phone for the session because of a weak signal or poor internet connection. Neither of these are considered HIPPA compliant. By signing this form, you agree to the use of these alternative platforms for your session when Doxy.me is not an available choice.

Therapeutic Process:

Based on attachment research, This therapist has found that meeting initially for 6 weekly consecutive sessions is the most therapeutic for the client. This assists in assessing the client's needs, identifying goals, and establishing rapport between client and therapist.

After the initial 6 sessions, client and therapist will review the sessions for effectiveness and adjust accordingly.

Please notify This Therapist of any issues that may compete with this process.

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Consent

By signing below, I/we acknowledge that I/we have received and understood the information in this Informed Consent and that my/our questions have been answered to my/our satisfaction.

I/we hereby authorize **DEBRA DALBY, LSCW** (This Therapist) to evaluate and provide treatment.

Additionally, I/we approve the following information that This Therapist may use to contact me for any number of reasons including confirming appointments, rescheduling or returning my phone call or email.

Address: ____

____

Home Phone Number: ______________________________

Work Phone Number: _______________________________

Cell Phone Number: _________________________________

Email: ____

____ ____________________

Client Date

Address: ____

____

Home Phone Number: ______________________________

Work Phone Number: _______________________________

Cell Phone Number: _________________________________

Email: ____

____ ____________________

Client Date

____ ____________________

Therapist Date