2121 S. Hiawassee Road, Suite 4663, Orlando, FL 32835
Phone: 321.465.9411 | Fax: 1.321.406.1426 |
Email: kevin.hardwick@lmfti.com | Website: www.lmfti.com

Participant Information / Informed Consent / Policies

Today's Date: _____
Name of Participant: _____
Date of Birth: _____ **Gender:** Male: ☐ Female: ☐
Address: _____
(Street) *(City)* *(State)* *(Zip Code)*
Cell Phone: _____ *O.K. to leave message?* *Yes* ☐ *No* ☐
Alternate Phone: _____ O.K. to leave message? *Yes* ☐ *No* ☐
Single/Never Married: ☐ **Live-in Partners:** ☐ **Married:** ☐ **Separated:** ☐ **Divorced:** ☐ **Widowed:** ☐

If Couple's or Family Therapy:
Name of Additional Participant: _____
Date of Birth: _____ **Gender:** Male: ☐ Female: ☐
Does 2nd Participant live at the same address or different address? *Same*: ☐ *Different:* ☐
Cell Phone: _____ *O.K. to leave message?* *Yes* ☐ *No* ☐
Alternate Phone: _____ *O.K. to leave message?* *Yes* ☐ *No* ☐
If a minor, names of parents: _____
Employer or School (If a minor): _____
Emergency Contact: _____ **Phone Number:** _____

CLIENT AGREEMENTS

This document provides you with some brief information about what you can expect when using the counseling services of **Lampein MFT Institute, Inc. (LMFTI)**. Please read carefully and sign below:

INFORMED CONSENT FOR TREATMENT

Copies of LMFTI's ***Statement of Participant's Rights*** and ***Limits of Confidentiality*** have been offered to me. I understand the contents of these documents and agree to abide by its terms to include giving general consent for treatment. I may at any time decline specific recommendations. General consent for treatment includes diagnostic evaluation, involvement in treatment planning, psychotherapy, & end-of-care (discharge) planning.

PARTICIPANT'S INITIALS: _____

PARTICIPANT CONFIDENTIALITY

You have the right to any current information concerning your assessment and recommended course of counseling, including expected duration of counseling. For the purposes of coordinating care, you have the right to review with members of our counseling staff access to your treatment plan, progress notes, and crisis plan (if applicable). Your records and transactions are confidential, unless release of these records is authorized in writing by you, or otherwise required by law, for example:

- **If a Participant threatens to harm someone (including self).**
- **If a Participant engages in irresponsible sexual activity while HIV positive.**
- **If a Participant uses recreational drugs or alcohol irresponsibly while pregnant.**
- **If a Participant has abused, is abusing, or is a threat in the future to abuse physically/sexually a minor or vulnerable adult.**
- **If a Participant is under age 18 and the counselor judges it is in the best interest of the Participant to share information.**
- **As part of an investigation and required by a court of law (subpoena).**

PARTICIPANT'S INITIALS: _____

LAMPEIN
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CRISIS POLICY

LMFTI therapists, interns, case management, therapy support, and/or administrative staff are not "on call" 24 hours/7 days per week. So, if you experience a life threatening emergency, please call 911 or go to the nearest emergency room.

PARTICIPANT'S INITIALS: _____

TELEPHONE ACCESSIBILITY POLICY

If you need to contact your therapist between sessions for coaching support, please leave a voice message on or text. Therapists and interns are often not immediately available; however, they will attempt to return your call within 24 hours. Please note that video sessions are highly preferable to phone sessions. However, in the event that you have poor receptivity, or are out of town, or sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

PARTICIPANT'S INITIALS: _____

SOCIAL MEDIA AND TELECOMMUNICATION POLICY

Due to the importance of your confidentiality and the importance of minimizing dual relationships, LMFTI therapists, interns, case management, therapy support, and/or administrative staff do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). LMFTI peer counselors may be an exception to this policy. LMFTI believes 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. If you have questions about this, please bring them up when you meet with your counselor and we can talk more about this policy. **PARTICIPANT'S INITIALS:** _____

EMAIL AND CELL PHONE USE (CYBER-COMMUNICATION) POLICY:

The use of email and cell phones to discuss therapeutic issues are *not secure*. While we would never share your email with anyone without your permission, email without encryption can be compromised. You agree that when you and LMFTI staff member(s) use email or cell phones, it will be under these conditions.

While staff members 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. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that:

- You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
- All existing confidentiality protections are equally applicable.
- Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee.
- Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent.

There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

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ONLINE/TELEHEALTH POLICY

Online psychotherapy, also known as telemental health services ("telehealth"), involves a therapist or counselor providing psychological counseling and support over the Internet through email, video conferencing, online chat, or phone calls. The information may be used for diagnosis, therapy, follow-up and/or education. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to mental health services by enabling the client to remain in his/her home or other remote site.
- Mental health services are more accessible and convenient—increasing mental health treatment outcomes.
- More efficient evaluation and continuity of mental health services.

Possible Risks:

There are potential risks associated with the use of telehealth services. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate decision-making by the counselor/therapist
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information

PARTICIPANT'S INITIALS: _____

CANCELLATION POLICY

LMFTI requires 24 hour notice for a cancellation. If notice has not been received, a cancellation fee of $40.00 will be charged to you. Any requests for exception to a failed appointment charge need to be sent in writing to the business office. **PARTICIPANT'S INITIALS:** _____

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. Your therapist will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential. **PARTICIPANT'S INITIALS:** _____

TERMINATION
(Ending of Your Therapeutic Work)

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Average length of LMFTI brief, solution-focused therapy interventions is between 12 - 14 sessions. Your therapist may terminate treatment after appropriate discussion with you and a termination process if LMFTI determines that the psychotherapy is not being effectively used or if you are in default on payment. Your therapist, intern, case manager, and/therapeutic support staff will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating.

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TERMINATION (Continued)

If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. ***Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, LMFTI must consider the professional relationship discontinued.*** **PARTICIPANT'S INITIALS: _____**

PAYMENT POLICY

It is LMFTI's policy to charge $150/hour ($37.50 per 15 minute increment) not to exceed a 90 minute session (1.50 hrs). Fees are due at the time services are rendered unless prior arrangements have been made. LMFTI accepts cash, Visa, MasterCard, Discover or American Express for payment of sessions. Upon request, a receipt is available for your records. **PARTICIPANT'S INITIALS: _____**

3rd PARTY BILLING POLICY

LMFTI is not a provider for any insurance company nor do we submit insurance claims. As such, LMFTI does not bill a Participant's insurance company, EAP, managed care group, or other paying organization for therapy services performed. Initial here to confirm that you understand and consent to services according to the LMFTI 3rd Party billing policy. **PARTICIPANT'S INITIALS: _____**

PARTICIPANT SIGNATURE

I am the party identified in the participant information above. I have read, understand and received a copy of this document for my records. My signature below indicates acceptance and agreement for therapy in accordance with the policies and practices outlined above.

_____ _____
Signature Date

_____
Printed Name:

How did you hear about LMFTI? ☐ **Social Media: _____** ☐ **Psychology Today** ☐ **Web Site**
☐ **Friend/Family** ☐ **Former Participant** ☐ **Pastor/Elder/Minister/Deacon**
☐ **Community Organization** ☐ **School** ☐ **Other:_____**