Informed Consent

NATURE OF TREATMENT TO BE PROVIDED: The therapists at Prairie Winds Healing, LLC provide outpatient mental health therapy. If you are engaged in therapy this generally means 45-60 minute sessions in the office on a weekly basis or more or less often. Usually, sessions start out on a weekly basis for as long as you and your provider feel it necessary and then sessions taper off as treatment goals are being achieved. Sessions can include one or more people in a family, providing the appropriate consents have been signed. Your therapist will discuss with you the length of time therapy is expected to last. This will depend on what your problem is and what your goals for treatment are. Your therapist will also talk with you about how often you will need to come in, in order for your treatment to be most effective.

THE TECHNIQUES IN USE: All new clients will be given a complete assessment. Based on the assessment and your stated problems, you and your therapist will develop a treatment plan that will guide your work together. As you and your therapist discuss your goals, your therapist will make a recommendation to you and the therapeutic techniques that might work best for you. If there is something you do not understand or agree with, you should inform your therapist. The treatment plan should spell out specifically what you will be focusing on in treatment, the expected outcomes, and how long treatment should take.

USE OF MEDICATION: Your therapist may refer you to a Nurse Practitioner, Psychiatrist, or physician for a mediation evaluation. If medication is prescribed, you have the right to refuse. If you refuse, your medical provider will explain the consequences and how this may affect your course of treatment. It is important that all health care providers work together. As such we would like permission to communicate with your primary care physician and/or psychiatrist. Your consent will be valid for one year. If you prefer to decline consent, no information will be shared. You may inform my physician _____ I decline to inform my physician_____

Physician name_____Clinic_____Address_____Phone_____

OUTCOME EXPECTATIONS: You and your therapist together can work on the issues that led you to seek assistance. You can expect your therapist to function in a professional manner and to bring all the skills he/she possesses to your aid.

RISKS OF THERAPY: During the course of therapy, your symptoms could worsen before they begin to improve. Painful memories might come to the surface. As you make positive changes in your life, this could affect your relationships with others. Any discomfort you feel is an issue for work with your provider.

CONFIDENTIALITY: What is discussed between you and your therapist remains confidential except: 1) When you authorize, in writing, a disclosure of information, 2) When there is an indication that harm may come to you or another identified person without disclosure, 3) When disclosure is demanded by the court, 4) when you are not the sole guardian, 5) when you give information about child abuse, all child abuse must be reported by Nebraska State Law 6) when dealing with a minor, parents have the right to access the notes of a child's therapy (with two exceptions) a)if the client were a minor in treatment for substance abuse problems, the minor would have to consent, in writing. b) a minor age 13 or older can consent to mental health crisis intervention services for the purpose of determining the severity of the problem and the potential for harm to the person or others if further professional services are not provided. These services cannot involve the use of medication.

HIPPA: Your HIPPA rights and responsibilities are located in a booklet in our waiting room. Please initial that you have been informed of your HIPPA rights. _____ initial here (If you would like a copy, please ask your therapist.)

CO-PAYMENTS are expected at the time of service. If you have not met your deductible, you will be required to pay the full fee at the time of service.

NO SHOW AND LATE CANCELLATION POLICY: As a professional, our time is valuable and therefore we have implemented a NO SHOW AND LATE CANCELLATION POLICY. A NO SHOW is defined as not giving a 24 hour notice if you should need to cancel an appointment.

CONSENT FOR TREATMENT OF A MINOR: I/We consent that _____may be treated as a client at Prairie Winds Healing. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide timely treatment for you and your children.

Signature: Date: