Into the Light
Mental Health and Consulting Services, Inc.
201 NW 4th St. Suite 105
Evansville, IN 47708
812-454-1564
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Consent to Treatment/Treatment Agreement

I, _____, do hereby consent to participate in treatment to be provided by Into the Light Mental Health and Consulting Services, Inc. I understand and agree to the following conditions of treatment and agree to abide by these conditions as follows:

_____ *I understand that all matters will be kept confidential as applicable by state and federal law and by the NASW Code of Ethics. I understand that there are some matters which must be reported to the authorities, such as if I disclose child abuse and provide identifiable information, have viewed child sexual victim images, have a plan to harm myself or others, or have harmed another vulnerable population. Additional information can be disclosed to insurance companies, attorneys, employees, billing personnel, interns, and ethics review boards.

_____ *I understand that this therapist is not always available for weekly appointments and sometimes has a lengthy wait list for appointment times. Clients are able to make emergency appointments if regular appointments are not available. If you require a higher level of care at this time, please take this into consideration before scheduling with this therapist.

_____ *I understand that in the event of a mental health emergency, I can call this therapist and schedule an emergency appointment. If this therapist is not available, I am aware that I can call my doctor's office, go to Deaconess Crosspointe, proceed to the nearest Emergency Room, or call 911 in the event that I plan on harming myself or others.

_____ *I understand that this therapist treats a variety of mental health conditions, but will refer clients on to a higher level of care if conditions are outside of the scope of what this therapist treats. This therapist will provide the names and contact numbers of at least 2 additional therapists that potentially might benefit the client. This therapist does not terminate clients from services unless client care is beyond the competency level of this therapist, or unless the client does not follow recommendations made by this therapist that would constitute an ethical dilemma. Clients will be made aware of this by this therapist and referred on to other services as needed.

_____ *I understand that the first two sessions with this therapist are on a trial basis to determine whether or not the client and therapist are an appropriate therapeutic fit and that this arrangement does not constitute a therapeutic/client relationship. Clients will be referred to another therapist if there is a conflict of interest, if client care is beyond the scope of what this therapist treats, and if either party is not comfortable proceeding with treatment in other conditions.

_____ *I understand that this therapist practices a no-secrets policy when working with couples, and clients are encouraged to be honest with their partner as soon as possible. Every effort will be made to support the client in doing so. This therapist also reserves the right to share or disclose information revealed by one partner

or family member in an individual session to the other partner or family members as deemed appropriate or necessary to support overall treatment progress and goals.

_____ *I understand that this therapist is not able to provide treatment to third parties that come to session with me unless this person is being seen by this therapist for couples counseling as this can be seen as an ethical dilemma. This therapist does not take progress notes or allow the session to focus on the additional person in order that the client might have the full benefit of the session.

_____ *I understand that I should arrive at therapy sober and not under the influence of any drugs and/or alcohol. If this therapist notices that I am intoxicated, the therapy session will be terminated, and appropriate transportation for me will be arranged. I will be charged the full fee for the session if I arrive intoxicated. This therapist reserves the right to contact law enforcement, and my confidentiality will be waived in the event that I choose to operate a motor vehicle while intoxicated as this is a reportable offense.

_____ *I understand that occasionally necessary communication to other professionals can include but is not limited to assessments, progress notes, and all homework maintained in my chart. This therapist consults with outside representation that can include but is not limited to other mental health professionals such as other therapists, my spouse's therapist, billing clerks, staff members, interns, attorneys, insurance companies, and ethics review boards. I give permission for this therapist to act on my behalf and to discuss my care as deemed appropriate by my therapist, noting that this therapist will release as limited information as possible to abide by the NASW Code of Ethics.

_____ *I understand that this practice does everything possible to protect my privacy and confidentiality. Privacy practices for Into the Light include the following: Information about me can be shared via the following communication methods and will include but is not limited to phone calls, postal mail service, internet servers, Telehealth, and faxing. While every attempt will be made to maintain confidentiality and comply with HIPAA, this therapist cannot guarantee absolute security in any of the aforementioned communication methods. My Protected Health Information (PHI), including identifying information regarding me such as psychotherapy notes, can be shared with insurance companies or their third party designees, consultation with other therapists regarding my care, billing clerks, staff members, interns, attorneys, judges orders to testify regarding me, ethics review boards, any and all government agencies or departments, if I indicate that I am going to harm myself or others, or if I've told my therapist that I have abused a vulnerable population.

_____ *I have read and understand Into the Light's notice of privacy practices and understand how my Protected Health Information (PHI) may be used.

_____ *I understand that emails and text messages are not HIPAA compliant, and that this therapist only uses these forms of communication when requested by me.

_____ *I would like to waive my rights under HIPAA and receive text message reminders and occasional email communication.

_____ *I understand that this therapist does not give copies of my psychotherapy progress notes to me or outside parties without a court order. A summation of therapy sessions can be requested for me or other providers. Additional copies can be made available for a fee. Please allow at least 4 weeks for this request.

_____ *I understand that this therapist will no longer follow me after 2 missed appointments, or after 1 month of no contact from me.

_____ *I understand that this therapist does not engage in dual relationships such as connections on social media or events outside of the office.

_____ *I understand that sexual contact is never acceptable in the therapeutic relationship. Romantic or sexual talk, flirting, sexual innuendos, and sexual jokes are unacceptable in the therapeutic relationship. This therapist reserves the right to terminate the session or the therapeutic relationship if this occurs.

_____ *I understand that hugging can be healing and supportive to many clients. If my therapist believes after discussing with me the request that a non-sexual hug is appropriate and supports therapy, hugs will be allowed on occasion with my permission and at my request.

_____ *I understand that my sessions will be conducted via phone or Telehealth if I am experiencing any stage of illness. My therapist will extend the same respect and consideration to me in the event that my therapist is ill and unable to see me in the office due to illness.

_____ *I understand that in order for Telehealth to be HIPAA compliant, this therapist will recommend platforms that comply with federal regulations. I understand that while I might choose not to participate in one of the recommended platforms, I cannot be guaranteed absolute privacy due to this. Also, I might request other platforms that are not HIPAA compliant in the event that federally approved platforms are not working with my technology.

_____ *I understand that the results of therapy cannot be guaranteed and that I might feel worse before I feel better.

_____ *I have thoroughly read and understand the Consent to Treat document and am being truthful to the best of my ability.

_____ *I understand that failing to initial this document or other documents in their entirety could cause a delay in treatment or a referral to a different provider.

_____ *I understand the conditions outlined above and agree to abide by the terms of this agreement. I understand that violations of this agreement may result in termination from this treatment program.

Client Signature*: _____ Date*: _____