# Individual Consent for Treatment

I understand that I will be engaging in psychotherapy with Teri Krull, LCSW. The purpose of this treatment is so I will feel better or resolve specific life or adjustment problems that have caused me to seek assistance. The primary procedure used by Ms. Krull is "talk" therapy. I understand that she may also provide general education about mental health conditions or coping strategies. She may also assign "homework" for me to do in between sessions. The potential benefit of treatment is that I will feel better about my life, learn to manage stress, experience relief from painful emotions, or resolve problematic issues. I understand that a "cure" is not guaranteed and that it is possible that as I talk about some things, I may even feel worse. I may experience emotions more intensely as I talk about things that are upsetting, or I may notice more conflict in relationships as we make changes in my behavior.

I understand that all information I share in therapy will be kept confidential, but that this confidentiality is not absolute. In the case of medical emergency, child/elder abuse or neglect, suicidal or homicidal intent, under court order or professional board complaint, clinical information may be released. I also understand that if my treatment is paid for by an insurance company, Ms. Krull will release clinical information to my insurer. In such cases, only that information required for billing will be released.

I understand that as an independently licensed social worker in Arizona and Maryland, Ms. Krull is not obligated to receive clinical supervision. However, in an effort to provide services that reflect best practices, she belongs to a consultation group composed of other therapists that meets regularly and she may consult individually with experts. I understand that if Ms. Krull discusses my case with a consultation group or with an expert consultant, identifying information is kept confidential to the extent necessary. Also, from time to time, emergency coverage may be provided by colleagues of Ms. Krull and when this occurs, she may disclose certain information as necessary to ensure appropriate coverage.

**Ms. Krull is conducting some treatment via telehealth. She most likely will use Sessions (HIPAA compliant) phone, ZOOM or FaceTime for client contact. If you request FaceTime or Zoom, your signature indicates your agreement with this form of contact which may not be HIPAA compliant.**

I understand that I can receive a copy of my records or have a copy of my records provided to another person by completing a Release of Information form. I understand that there is a usual and customary charge for chart retrieval, chart review, copying of records, and a one-on-one meeting with Ms. Krull. This meeting is required prior to personal receipt of my record. I acknowledge that Ms. Krull has discussed her policy regarding release of records when litigation may be involved.

I understand that I have the right to participate in treatment decisions and that Ms. Krull and we will together develop and periodically review and revise a treatment plan which will identify goals for treatment as well as the means of achieving those goals. I understand that I have the right to refuse any recommended treatment and that I may withdraw my consent to treatment at any time with no consequences.

I understand that Ms. Krull bills at the following rates:

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| Initial Diagnostic Interview (60-80 minutes) | $245 | Group Psychotherapy | $ 80 |
| Individual Psychotherapy (20-30 minutes) | $ 80 | Telephone Consultation (per 15 minute segment) | $ 45 |
| Individual Psychotherapy (45-50 minutes) | $145 | Family Psychotherapy | $195 |
| Individual Psychotherapy (70-80 minutes) | $195 | No Show Fee | $145 |
| | | Charge card fee | $ 3 |

Ms. Krull does not contract with insurance companies and charges on a self-pay basis. I understand that I will be billed for cancelled sessions unless I give Ms. Krull **24 hour notice** and that since most insurance companies will not pay a missed session fee I will be responsible for paying this fee. I understand that our insurance company is under contract with me and/or my employer and not with Ms. Krull, that I am ultimately responsible for all charges incurred for therapeutic services, and that Ms. Krull may use a collection agency if fees are not paid within a reasonable time frame. *I have read the above information and consent for treatment. This consent is valid backdating to the last signed consent and will be valid at least one year from the date of signature.*

Signature:_____ Date:_____

Therapist:_____ Date:_____

**Teri V. Krull, LCSW, LLC**

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