Emily Lapetino, LCPC

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**Consent to Participate in Psychotherapy**

**Psychotherapy Information Disclosure Statement**

Therapy is a relationship that involves clearly defined rights and responsibilities for each person involved. This frame helps to create safety, and to clarify the goals, benefits, and limitations of therapy. As a client in therapy, you have the right to be informed of these benefits and limitations.

**Confidentiality**

You have the right to confidentiality in your therapy sessions. Any and all information communicated in sessions will be held in strictest confidence. None of what is said or done will be divulged verbally or in writing without your written permission, except in cases of emergency, as described below. If I determine that consultation is necessary to your treatment, I will consult with another professional, keeping your identifying information confidential.

Your privacy is also protected under the provisions of the Federal Health Insurance and Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you. Any information regarding you that is transmitted electronically will be done in a confidential manner.

**Email and Text Messaging**

All electronic communication will be limited to scheduling or logistical information. Extensive details regarding your personal and therapeutic concerns will occur in person during the therapy session. Emails that contain anything more than scheduling information will be saved for discussion at the next scheduled appointment. This measure is taken as a practical concern and also to help protect your privacy. Please note that any emails or text messages you send will be protected to the best of my ability, but I cannot ensure 100% confidentiality.

I will respond to electronic communication within 24-48 hours. In cases of emergency, please contact me via phone call. I cannot respond to emergency emails or text messages.

**Limits to Confidentiality**

The following are legal limitations and exceptions to your confidentiality:

* **Harm to Self.**  If there is reason to believe that you are in clear and imminent danger of harming yourself, I will need to take steps to ensure your safety. This may mean breaking confidentiality to call the police or a crisis team, or involving a family member in safety planning. If you are unable to act to ensure your own safety, I will need to do so.

* **Harm to Others.** If there is reason to believe that you will harm someone else, I am legally required to contact that person and inform them of your intentions. I am also legally required to call the police and ask them to protect your intended victim.
* **Child Abuse or Abuse of a Developmentally Disabled Person.**  If there is reason to believe that you have abused or neglected a child or developmentally disabled adult, I am legally required to inform the Illinois Department of Children and Family Services within 24 hours and/or Adult Protective Services immediately.

**Fees and Insurance**

My fee is $150 for a 55 minute session. Payment is due at the time of each session. If you have a medical policy that covers counseling, I will submit claims directly to your insurance company on your behalf. If you have Blue Cross Blue Shield if Illinois PPO or Cigna, I will collect payment for services from your insurance company directly in most cases (check with your insurance company for details).

You will be responsible for your own deductible and co-payment. If the fees you expect your insurance company to cover are rejected for any reason, those fees remain your responsibility to pay. If you intend to utilize your insurance company to assist with the cost of therapy, please know that you waive your confidentiality. Insurance reimbursement may require a disclosure of your presenting problem, diagnosis, and treatment program.

**Cancellation Policy**

If you need to cancel or reschedule a session, please provide 24-hour notice (except in cases of emergency or unexpected illness). I will allow one missed session without charging a cancellation fee. However, if a second session is missed without notice, and is not an emergency, a $50 cancellation fee will be applied. Please note that insurance cannot be billed for missed sessions.

**Other Rights**

You have the right to fair and equal treatment that does not discriminate against you in any way, including but not limited to: age, gender, race, religious belief, ethnic origin, sexual orientation, marital status, physical or mental disability, or criminal record that is unrelated to present dangerousness. You have the right to culturally competent care, which recognizes and accepts differences in cultural values, beliefs, and practices.

You have the right to be informed of service fees prior to starting therapy. You have the right to refuse services at any time, and are free to leave therapy at any time. You have the right to ask about my credentials and experience, and can request a referral to another therapist at any time. When you decide to leave counseling, I would request a week’s notice so that we can summarize the work done and provide a sense of closure.

**Therapist Training and Therapeutic Approach**

I have a Master of Arts Degree in Counseling Psychology from Trinity International University. I am a Licensed Clinical Professional Counselor (LCPC) in the State of Illinois. My areas of specialty include depression, trauma, abuse, grief and loss, relational conflict, and life transitions, and I work with adolescents, adults and couples. I typically utilize a combination of a client-centered, cognitive-behavioral and trauma-informed approach to therapy.

**Client Consent to Therapy**

I have read and understand this consent to participation in therapy, to the use of a diagnosis for billing purposes, and to the release of information necessary to complete the billing process. I agree to pay any co-payment required by my health insurance company for each therapy session I attend, and understand I am responsible for any charges that my insurance company will not cover. I agree to participate in therapy with Emily Lapetino, LCPC, and understand that I can refuse any suggestions made by Emily and/or end my participation in therapy at any time, without prior notice.

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Client Signature

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Therapist Signature