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## **Informed Consent for Psychotherapy**

**CONFIDENTIALITY:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law.

**WHEN DISCLOSURE IS REQUIRED OR MAY BE REQUIRED BY LAW:** IPCS Clinician is required to disclose confidential information; where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to IPCS Clinician that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding.

**EMERGENCY:** If there is an emergency during therapy, or in the future after termination, where IPCS Clinician becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he will do whatever he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care.

**HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS:** Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. Only the minimum necessary information will be communicated to the carrier. IPCS Clinician has no control over the insurance companies' handling of this information.

**LITIGATION LIMITATION:** The nature of the therapeutic process often involves making a full disclosure with regard to many personal and confidential matters. Thus, it is agreed that, should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on IPCS Clinician to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

**CONSULTATION:** IPCS Clinician consults regularly with other professionals regarding his clients in order to continuously improve his services; however, each client's identity remains anonymous and confidentiality is fully maintained.

**ONLINE AND OTHER OF-SITE COMMUNICATION:** It is important to be aware that computers, e-mail, texts, and other online communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. If you communicate confidential or private information via online, texts, fax or phone messages, it assumes that you have made an informed decision, and will be seen as your agreement to take the risk that such communication. Please do not use texts, e-mail, voice mail, or faxes for emergencies. IPCS Clinician may agree to conduct sessions via Skype or another program, however, you should be informed that such communication is not encrypted.

**RECORDS AND YOUR RIGHT TO REVIEW THEM:** Both the law and the standards of IPCS Clinician's profession require that he keep treatment records for at least 5 years. Unless otherwise agreed to be necessary, IPCS retains clinical records only as long as is mandated by Virginia law. If you have concerns regarding the treatment records, please discuss them with IPCS Clinician. As a client, you have the right to review or receive a summary of your records upon request. IPCS Clinician will also release appropriate information to agencies/persons you authorize.

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact IPCS Clinician between sessions, please e-mail or call and leave a message. IPCS Clinician will get back to you as soon as possible. If an emergency situation arises, you need to call your local community mental health center, crisis center or 911.

**THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships, resolution of the specific concerns that led you to seek therapy, and achieving positive change in your life. Working toward these goals, however, requires your active involvement, honesty, and openness. IPCS Clinician will draw on various psychological approaches, which include, but are not limited to, cognitive-behavioral, system/family, developmental, humanistic or psycho-educational.

**TREATMENT PLANS:** Within a reasonable period of time after the initiation of treatment, IPCS Clinician will discuss with you his/her working understanding of the problem, treatment plan, therapeutic objectives, and his view of the possible outcomes of treatment. If you have any unanswered questions, please ask. You also have the right to ask about other treatments for your condition and the risks and benefits.

**TERMINATION:** After the first couple of meetings, and during the course of therapy, IPCS Clinician will assess whether your participation in therapy with him can be of benefit to you. If at any point, IPCS Clinician either assesses that he/she is not effective in helping you reach the therapeutic goals, he/she will discuss with you the termination of treatment. You also have the right to terminate therapy.

**DUAL RELATIONSHIPS:** It is important to realize that in some communities, particularly small towns, military bases, university campus, etc., you may see IPCS Clinician in other settings outside your therapy sessions with him. IPCS Clinician will never acknowledge working with anyone without his/her written permission. Please advise IPCS Clinician if you have concerns regarding any social relationships outside therapy sessions.

**PAYMENT:** You are responsible for co-payment, co-insurance and deductible amounts if you are using insurance. If you are not using insurance, you will be responsible for paying for sessions at a rate agreed with IPCS Clinician. Usual rates are listed on the IPCS website. Separate fees are assessed for services not covered by insurance, such as preparing written documents. There will be a charge of \$25 if appointments are canceled without an advance notice.

**HIPPA:** HIPPA Notice of Privacy Practice have been provided to you on a separate form.

I have read the above Informed Consent for Psychotherapy and HIPPA Notice of Privacy Practice; I understand them and agree to comply with them:

**Client's Name (print)** \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent/Guardian's Name (print)** \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Psychotherapist's signature:**

Signature \_\_\_\_\_ Date \_\_\_\_\_