

# Mariah McQueen, M.A.

Licensed Marriage & Family Therapist #120401

## ***Informed Consent***

### **The Therapy Process**

**What is therapy?** I believe that as humans, we are wired to need and desire certain fundamentals from ourselves and others: safety, acceptance, comfort, love, and belonging, to name a few. These elements are what lay the foundation for a fulfilling life. However, in trying to pursue these fundamentals, we often find ourselves stuck in repetitive patterns that leave us experiencing the opposite of what we desire: insecure, rejected, hurt, overlooked and isolated.

As a marriage and family therapist, my hope is to create a space where we can deconstruct these patterns that are not working for you by understanding where they came from and what functions they've played - no one does anything for no good reason. We can then learn how to create new patterns to pursue and receive what we deeply need and desire from ourselves and others.

### **What therapy is not:**

- *Therapy is not a guarantee* that the goals you bring with you into therapy will be achieved. Through the process of therapy, you may find a different outcome than when you first started working with me.
- *Therapy is not about always feeling good.* Therapy can provide many benefits, while at the same time bringing discomfort or distress from processing painful situations and emotions. Oftentimes, clients report feeling worse before they feel better.
- *Therapy is not a "cure-all."* There may be times when I suggest other avenues of support that could supplement the work we are doing together.
- *Therapy is not a social relationship.* As your therapist, I hold our therapeutic relationship in the strictest of confidentiality. That means I do not accept requests to be connected on social media (including LinkedIn) and if we see each other outside of therapy, I will not acknowledge our knowing each other unless you do first.
- *Therapist is not forever.* You may discontinue therapy at any time. If you or I believe that you are not benefiting from treatment, then either can initiate a discussion of other possibilities, such as referrals, changing your treatment plan, or ending therapy.

### **My Role as Therapist**

In addition to my graduate coursework in Marital + Family Therapy, I have completed extensive training in the Emotionally Focused Therapy (EFT) model of individual, couple's and family therapy. I also participate in regular consultation with colleagues, attend trainings about topics that are relevant to my work and my clients, stay updated about current trends and research within the field, and educate myself about resources within the community.

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## **Mental Health Emergencies**

Should you experience a mental health emergency while working with me, you are welcome to call me after hours. However, I am not a 24 hour crisis line and my answering will be based on my availability. If I am not immediately available, leave me a voicemail, email or text message and I will respond as soon as possible. Then, please call the **San Diego Crisis Line** at **888-724-7240**, the **National Domestic Violence Hotline** at **800-799-7233** or call 911. If I am available to answer, calls longer than 15 mins will be billed at our agreed upon hourly rate. In the event that I am away from the office and not able to provide after hours support, I will provide you with a list of available therapists in addition to the emergency numbers above.

## **Terminating Therapy**

Both you and I have a right to terminate therapy at any point. Reasons I might terminate therapy include frequent missed sessions, frequent missed payments, non-compliance with treatment recommendations or referrals, conflicts of interest or dual relationships, if your treatment needs are outside of my scope of competence or require a higher level of care, etc. In addition, if I do not hear from you for 30 days, I will no longer be holding space for you in my caseload and any future sessions will be subject to my availability. I will not terminate our therapeutic relationship without making significant attempts to work with you to remedy any issues and would provide you with referrals to other therapists/treatment programs that might better fit your needs.

Going forward in this document, "I" or "me" refer to Mariah McQueen in the role of your marriage and family therapist.

\_\_\_\_\_ **(Initial) I read and understood the above regarding The Therapy Process.**

## **Privacy + Confidentiality**

You have a right to privacy concerning your medical information, which includes information you share with me and the work that I do with you. The concept of medical information also includes your name, address, e-mail address, telephone number, and social security number. By law, I have a legal duty to keep your medical information reasonably safe and secure. In general, what you share with me during our sessions is confidential, meaning I cannot share this information with third parties without your written authorization. Especially for the permitted exceptions to confidentiality, my preference, if at all possible, is to only disclose your medical information with your written authorization.

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**Mandated (Required) Disclosures** Although you have a right to privacy concerning your medical information, I am a mandated reporter. As such, I am required by law to report certain information shared with me, in order to ensure the safety of clients and others. The following are circumstances in which I am mandated to share confidential information:

1. **Child Abuse + Pornography.** I must report the following to Child Welfare Services or law enforcement:

- If I have reasonable suspicion that a minor is currently experiencing/has previously experienced any of the following: physical abuse, sexual abuse, sexual exploitation, neglect, or endangerment
- If I am aware of consensual sexual activity between a minor under 14 years of age and another party 14 years of age or older, or a minor who is under 16 years of age and another party who is 21 years of age or older
- If I am aware of a person who knowingly develops, duplicates, prints, downloads, streams, accesses through any electronic or digital media, or exchanges, a film, photograph, and/or video in which a child is engaged in an act of obscene sexual conduct

2. **Elder/Dependent Adult Abuse.** I must report the following to Adult Protective Services or law enforcement:

- If I have reasonable suspicion that an elder (under California law, an elder is defined as someone who is over the age of sixty-five and resides in California) or a dependent adult (under California law, a dependent adult is defined as someone between the ages of 18 and 64 who has physical or mental limitations that affect his or her ability to carry out normal life activities or protect his or her rights) is currently experiencing/has previously experienced any of the following: physical abuse, sexual abuse, sexual exploitation, neglect, financial abuse, abandonment, isolation or abduction

3. **Harm to Others.** I must contact law enforcement, and warn the intended victim(s) if:

- You (or your immediate family) communicate to me a serious, imminent threat of physical violence against a reasonably identifiable victim(s), and I believe you have the means to carry out this threat

4. **Court Order.** I must comply with disclosing confidential information if a court, board, commission, or administrative agency compels me to do so.

5. **Search Warrant.** I must comply with a search warrant lawfully issued to a government law enforcement agency, that compels me to disclose your medical information. National and Homeland Security, and the Department of Defense, may

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also require me to disclose your medical information and prohibit me from sharing this with you.

**Confidentiality with Third Parties** Although you have a right to privacy concerning your medical information, there are certain exceptions where confidentiality may be broken. The following are circumstances in which I am allowed (but not required) to share confidential information:

1. *Other Health Care Providers.* I may consult with your physician/psychiatrist/ other mental health care clinician about your diagnosis and/or treatment.

2. *Danger to Self/Others.* I may disclose medical information to a third party (i.e. law enforcement) if I believe you are dangerous to yourself or others, and believe that involving a third party will prevent or lessen an imminent risk of physical harm to yourself and/or others.

3. *Reimbursement.* I may disclose your medical information to a third party who is providing reimbursement for services (i.e. insurance company, Victims of Crime). Many third party payers require medical information such as dates and times of service, a diagnosis code and treatment progress.

4. *Bill Collection.* I may release financial information to a collection agency, attorney or small claims court, if you are delinquent in paying your bill.

5. *Electronic Communication.* If you choose to communicate with me via email and/or text messaging, third parties may intercept cell phone and non-encrypted email communication.

6. *Child Emotional Abuse.* I may disclose information to Child Welfare Services or law enforcement if I am aware that a minor is currently experiencing/has experienced emotional abuse (i.e. behavior that causes a child mental suffering).

**Professional Consultation** I regularly participate in consultation meetings with colleagues in order to address various legal and/or ethical challenges, improve my skills as a therapist, and invite recommendations about a course of treatment. During these meetings, I will not reveal any of your specific identifying information and will only disclose information related to the feedback I need.

\_\_\_\_\_ **(Initial) I read and understood the above regarding Privacy + Confidentiality.**

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## Couples & Families

**Confidentiality:** If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information.

**No Secrets Policy:** When working with couples and families, the “client” is the relationship, rather than the individuals. Therefore, it is important for me to remain neutral between the parties. As a general rule, I do not keep secrets for individuals. If something is shared over the phone, in an email, in an individual session, etc. that I believe is important to the relational work, I will help that person disclose the information next session in a respectful, clinically appropriate manner. This policy is

in place to avoid situations creating conflicts of interest. If there are relational topics that you would like support with but are not comfortable bringing them to couples or family therapy, individual therapy would be a more appropriate resource. Exceptions to this rule usually involve issues of physical safety.

\_\_\_\_\_ **(Initial) I read and understood the above regarding Couples & Families.**

## Legal Matters

**The Psychotherapist-Patient Privilege** There are occasions when therapy intersects with legal matters, such as when therapists are subpoenaed to testify in court and/or release therapy records. In attempts to protect your privacy, the psychotherapist-patient privilege (“Privilege”) prevents a therapist from testifying about a client’s therapeutic process. If you are involved in a legal proceeding, or become involved in one after therapy has commenced, you may benefit from consulting with your attorney about how your involvement in the legal proceeding may impact your right to the protection of Privilege. If I am subpoenaed as your therapist, I will first assert Privilege on your behalf and will do so until you (or someone acting on your behalf) waive Privilege, or a judge (or some other judicial or administrative officer) orders me to testify or disclose confidential information. If privilege is waived and I am required to testify, I can only testify to facts and my testimony may not solely be in your favor.

**Subpoenas/Requests for Professional Records** On occasion, therapy records are requested or subpoenaed for various reasons. Therapy records include intake forms, the informed consent contract, assessment tools, progress notes about sessions, phone calls, etc., any Releases of Information, and billing documents. If therapy records are requested, subpoenaed or required to be released, I often suggest providing a treatment summary in place of the full record, as you may not want the

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full details of therapy to be disclosed. However, there are occasions when I may be ordered to turn over your full therapy record.

**Expert Witness Fees** If you require me to attend a deposition, hearing, or other legal proceeding to testify about your treatment, there will be a \$250 per hour with a four-hour minimum fee for any such testimony.

\_\_\_\_\_ **(Initial) I read and understood the above regarding Legal Matters.**

## **Patient Notice of Privacy Practices**

In 2000, the United States Department of Health and Human Services established the Privacy Rule, to act in accordance with the Health Insurance Portability +

Accountability Act (HIPAA). The Privacy Rule was created to both protect your health information while also allowing that information to be shared amongst those involved in a client's care, including healthcare providers, health plans, etc. The Privacy Rule accords you the following regarding your Protected Health Information (PHI):

1. *To refuse (in writing) to consent to the use or disclosure of your PHI.*
2. *To refuse to disclose all or part of your PHI after initially giving your consent.* You may not revoke actions that have already been taken which relied on a previously signed consent.
3. *To receive an account of any disclosures I made regarding your PHI.*
4. *To request (in writing) and receive a copy of your PHI.* If agreed upon, I will provide you with a summary of your PHI provided that you agree with this arrangement. In certain situations, I may deny your request and will communicate in writing the reasons for the denial, which you may have reviewed.
5. *To ask me to amend your PHI.* If I deny your request, you may file a disagreement and prepare a rebuttal, which will be added to your PHI.

If you believe that I have violated the Privacy Rule, you may also file a complaint with Health and Human Services.

\_\_\_\_\_ **(Initial) I read and understood the above regarding the Privacy Rule.**

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## Payment + Cancellation Fees

**Fees and Insurance** The agreed-upon fee for therapy is \$ \_\_\_\_\_ per 50-55 minute session. Fees are payable at the time of each session, with a check, credit card or cash. I am able to keep a credit card on file for you and can charge your card after each session. My fees are raised by 5-10% annually on September 1st each year. This will apply after 6 months of working together. If the financial cost of therapy becomes problematic, please let me know and we can talk about various options for making therapy more affordable.

As I am an out-of-network provider, I do not accept any insurance directly. However, some insurance plans reimburse for a portion of the cost of therapy. If you would like to be reimbursed by your insurance company, it is your responsibility to submit claim forms for reimbursement to your own insurance company. I can provide you with a statement detailing session dates, fees and provider information, which you can then be included with your claim form.

**Cancellation Fees** If you are unable to attend your scheduled appointment, please notify me at least 24 hours in advance of the scheduled session. Otherwise, you will be charged 100% of your session fee. This cancellation charge is not a penalty for missing a session; rather, the cancellation fee is compensation for my inability to schedule other clients for the day and time of your canceled session. Exceptions are made for extenuating circumstances on a limited basis and are based on my discretion.

\_\_\_\_\_ (Initial) I read and understand the above regarding Payment + Cancellation Fees.

## Communication

**In Between Sessions** Occasionally, clients need to connect with me outside of our therapy sessions. Please indicate the way(s) that I can reach out to you if you need to connect with me outside of one of our sessions:

\_\_\_ Phone call w/o leaving a message    \_\_\_ Text message (\*\*unencrypted)  
\_\_\_ Phone call and leave a message    \_\_\_ Email (\*\*unencrypted)

**Emergencies** As I am not always immediately available when you reach out to me, please call 911 or the San Diego County Crisis Line (888-724-7240) for emergency assistance. In addition, you may also notify me via email or voicemail if you have an urgent request, and I will reach out to you as soon as possible.

3033 5th Ave. Suite 235  
San Diego, CA 92103  
T. 619-940-4083

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**Email/Text** As email and text communications are unencrypted, and thus not confidential, please **do not use email or text to communicate issues related to what we discuss in therapy.** I advise using email and/or text for matters such as scheduling requests, notifying me if you are late to session, etc. All email and text communication I receive from you is kept in your treatment record.

**Phone** If you need to connect with me outside of our session, I'm more than willing to schedule a 10-15 minute phone call with you. If you anticipate the phone call requiring more than 15 minutes, then we can discuss scheduling a session or paying for a longer phone call.

\_\_\_\_\_ **(Initial) I read and understood the above regarding Communication.**

## Telehealth

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in Privacy + Confidentiality section above also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible



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because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)].

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

\_\_\_\_\_ **(Initial) I read and understood the above regarding Telehealth.**

**I acknowledge receipt and understanding of this Informed Consent, and I have been given the opportunity to ask questions or share concerns about any part of this Informed Consent.**

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

Printed Name: \_\_\_\_\_

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_