MARCIA W. HEMLEY, PH.D., P.C.
Licensed Psychologist – Doctorate
92 Adams Street, Burlington, VT 05401 863-6114

INFORMED CONSENT

The information described below is offered to anticipate the most frequently asked questions about my professional services and business practice. Please read this carefully. If you have questions, it is important that you clarify them with me prior to signing this document.

PSYCHOTHERAPY: You have voluntarily elected to receive psychotherapy services from Marcia W. Hemley, Ph.D., P.C., and you understand you may terminate therapy at any time. You understand that there is no assurance you will feel better. You agree to work with me in a cooperative manner to resolve your difficulties. During the course of treatment, material may be discussed which could be upsetting in nature, and this may be necessary to help resolve problems.

APPOINTMENTS: Therapy sessions are between 50 minutes and an hour unless special arrangements are made. I will schedule my own appointments and make every effort to arrange appointment times that are convenient for you. The time agreed upon is reserved for you. IN THE EVENT THAT YOU MUST CANCEL AN APPOINTMENT, PLEASE CALL ME AT LEAST 24 HOURS IN ADVANCE. FAILURE TO GIVE ADEQUATE NOTICE WILL RESULT IN YOUR BEING BILLED FOR THE APPOINTMENT. Insurance companies cannot be billed for this cost. In the event of an emergency cancellation, when 24 hour notice is not possible, I will try to reschedule your appointment within a week or two, without additional charge.

PHONE CALLS: Messages are taken by my answering service. I pick up these messages periodically throughout the day and will return calls as soon as possible.

FINANCIAL: You are responsible for the payment of all applicable fees at the time of the visit. If you are the parent or guardian of a minor, all charges not covered by your insurance company will be your responsibility. If you have questions regarding your bill, you may call my office at 863-6114.

FORENSIC FEE: Note that if I must be involved in litigation because of services provided to you: (1) I must be paid a forensic fee, which will be different from my regular in-office fee; (2) a retainer must be paid in advance, which will be an estimate of the minimum time that will be required for forensic services; and (3) out-of-office services will be charged on a portal-to-portal basis. The forensic fee will be applied to all services connected to litigation, including but not limited to telephone conferences, preparation of reports, depositions, and court appearances.

FEES and INSURANCE: If you choose to use insurance coverage for psychotherapy, you are responsible for providing me with your insurance information and all forms that are necessary to receive payment. If your insurance coverage changes, it is your responsibility to inform me to avoid any lapse in coverage or billing. You are responsible for insurance company deductibles and co-pay/coinsurance fees. Exclusions: Most insurance plans do not cover involuntary or court-ordered treatment or any psychological services for the purpose of satisfying a legal obligation.

If, for some reason, your insurance does not cover the cost of the psychotherapy services I have provided, the ultimate responsibility for payment is yours. Accounts delinquent beyond 90 days may be turned over to a collection agency or attorney for payment in full. If you do not have insurance or elect not to use it, we will agree on the amount you will pay for our sessions.

MANAGED CARE PATIENTS: Pre-authorization of services may be necessary for receiving insurance reimbursement. Please check with your insurance company. I belong to many of the managed care provider networks. However, each plan has its own case referral and review process so it is important that you verify your coverage. If you will be using benefits under a managed care plan, I may be required to provide information related to your case to the managed care reviewer and your primary care physician.

CONFIDENTIALITY: Your right to confidentiality is protected by Federal and State law. Information about you which you disclose in session will not be repeated without your written consent except in the following situations:

1) If you are a danger to yourself, others, or the property of others, I am required by law to take measures to protect the safety of all involved.
2) I am required by law to report cases of abuse or suspected abuse of children, the elderly, or disabled individuals to the appropriate state authorities.
3) I may be required to divulge information and records by court order or subpoena. This usually occurs in situations involving the need for hospitalization, child custody, or personal injury lawsuits.
4) Occasionally, to insure the highest standards of care, mental health professionals consult with colleagues. During such consultations, care is taken to protect the identity of the patient.
5) If circumstances beyond my control were to result in my being incapacitated and unable to notify you, myself, of my unforeseen availability, you will be contacted by one of my colleagues.
6) I may be requested to disclose any and all records pertaining to your treatment to your insurance or managed care company and to your primary care physician, if such disclosures are necessary for claims processing, case management, coordination of treatment, quality assurance, or utilization review purposes.

I have read below the basic rights of individuals who receive psychotherapy treatment. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision about whether to accept or refuse treatment.
5. The right to contact and consult with counsel and select practitioners of my choice at my expense.

I understand I can revoke my consent at any time except to the extent that treatment has already been rendered or action has been taken in reliance on this consent. I understand that my consent expires when I revoke it.

I have read, understand, and agree to all of the above. My signature also acknowledges that I have been given the professional qualifications and experience of Marcia W. Hemley, Ph.D., and a listing of actions which constitute unprofessional conduct according to Vermont statutes.

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Signature of Patient/Client Date