

CLIENT NAME \_\_\_\_\_

CLIENT NUMBER \_\_\_\_\_

**Sam Miller, Th.D./M.A./LMHC**-FL. Lic. #MH8884  
Samaritan Counseling Services of the Gulf Coast (SCSGC)

### ***Informed Consent Statement***

Thank you for the opportunity to serve as your psychotherapist. This information is designed to inform you of my educational and professional background, and to ensure that you **understand** our professional relationship.

**Education & Credentials:** I received the Master of Divinity Degree from Yale University in 1979. After nine years of serving as an ordained minister in parish, hospital, and campus ministries, I began specialized ministry as a Pastoral Counselor. I have been a Certified Professional Pastoral Counselor (A.A.P.C.) since 1992, and a Certified Imago Relationship Therapist since 1994. I received the Th.D. degree in Pastoral Counseling from Emory University in 1996. Prior to joining the staff here at SCSGC, I served for ten years as a Staff Therapist at the Samaritan Counseling Center of the Mohawk Valley in Utica, N.Y.

I currently hold the following professional licensures and certifications:

- American Association of Pastoral Counselors (AAPC), Fellow # 4297
- Certified Imago Relationship Therapist (Clinical Member, Association for Imago Relationship Therapy, AIRT)
- Licensed Mental Health Counselor (FL. Lic. # MH8884)

I provide counseling services that are both faith-based and research-validated to individuals, couples, and families. **With individuals, I specialize in resolving emotional and behavioral problems with depression, anxiety, anger, skin diseases, sexual addiction, and chronic pain. I also specialize as a relationship therapist with both singles and couples, and as a specially-trained parenting educator with families.** I have extensive training and experience in the integration of psychological science with traditional spiritual values and wisdom.

**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 By Law:** Some of the circumstances where disclosure is required by the law are: 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 client's family members communicate to me that the client presents a danger to others.

**When Disclosure May Be Required:** Disclosure may be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by me as your therapist. In couple and family therapy, or when different family members are seen

individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. I will use my clinical judgment when revealing such information. I will not release records to any outside party unless he is authorized to do so by all adult family members who were part of the treatment.

**Minors in therapy:** If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is my policy to request a written agreement from your parents or guardians indicating that they consent to give up access to such information and/or to your records. If they agree, I will provide them only with general information about our work together subject to your approval, or, if I feel it is important for them to know in order to make sure that you and people around you are safe. If I think it is appropriate, I will involve them if I feel that there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, I will discuss the matter with you, if possible. I will do the best I can to resolve any differences that you and I may have about what I am prepared to discuss.

**Emergencies:** If there is an emergency during our work together, or in the future after termination where I become concerned about your personal safety, the possibility of your 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. For this purpose, he may also contact the person whose name you have provided on the biographical sheet.

**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. As your therapist, I have no control or knowledge over what insurance companies do with the information he submits or who has access to this information. ***You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job. The risk stems from the fact that mental health information is likely to be entered into big insurance companies' computers and is likely to be reported to the National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been also reported to be legally accessed by enforcement and other agencies, which also puts you in a vulnerable position.***

**Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, 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 me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

**Consultation:** I consult regularly with other professionals regarding my clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.

**E - Mails, Cell phones, Computers and Faxes:** It is very important to be aware that computers and e-mail and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, my e-mails are not encrypted. Faxes can easily be sent erroneously to the wrong address.

My computers are equipped with a firewall, a virus protection and a password. I also back up all confidential information from his computers into CDs on a regular basis.

Please notify me if you decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or Faxes. If you communicate confidential or highly private information via e-mail, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and he will honor your desire to communicate on such matters via e-mail. Please do not use e-mail or Faxes for emergencies.

**Records and Your Right to Review Them:** Both the law and the standards of my psychotherapeutic profession require that I keep appropriate treatment records for at least 5 years. I retain clinical records only as long as is mandated by Florida law. If you have concerns regarding the treatment records please discuss them with me. As a client, you have the right to receive a summary of your records upon request, except in limited legal or emergency circumstances or when I assess that releasing such information might be harmful in any way. In such a case I will provide the records summary to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I assess that releasing such information might be harmful in any way. When more than one client involved in treatment, such as in cases of couple and family therapy, I will release records only with the signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

**TELEPHONE & EMERGENCY PROCEDURES:** If you need to contact me between sessions, please leave a message on the answering service (941) 926-2959 and your call will be returned as soon as possible. You may also call me on my business cell phone, 941-323-3536. I check my messages a few times during the daytime only, unless I am out of town. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call Bayside Center for Behavioral Health of Sarasota Memorial Hospital at 1-800-764-8477 or 917-7760, or the Police: 911. Please do not use e-mail or Faxes for emergencies. I do not always check his e-mail or Faxes daily.

**PAYMENTS & INSURANCE REIMBURSEMENT:** *Clients are expected to pay the standard fee of \$100.00 per 45 minute session at the end of each session unless other arrangements have been made. An extra \$15 charge is added to the first session to cover the costs of the intake evaluation. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed upon otherwise.* Please notify me if any problems arise during the course of therapy regarding your ability to make timely payments. ***Clients who carry insurance should remember that professional services are rendered and charged to the clients and not to the insurance companies. Unless agreed upon differently, I will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As***

***was indicated in the section Health Insurance & confidentiality of records, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are dealt with in psychotherapy, are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.*** If your account is overdue (unpaid) and there is no written agreement on a payment plan, I can use legal or other means (courts, collection agencies, etc.) to obtain payment.

**MEDIATION & ARBITRATION:** All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement between me and my client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Sarasota or Manatee Counties in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I am at liberty to use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

#### **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 and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc, or experiencing anxiety, depression, insomnia, etc. As your therapist, I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, I am likely to draw on various psychological approaches according, in part, to the problem that is being treated and my assessment of what will best benefit you. These approaches include, but are not limited to, behavioral, cognitive-behavioral, schema-focused, emotion-focused, psychodynamic, existential, system/family, developmental (adult, child, family), humanistic or psycho-educational. I provide neither custody evaluation recommendation nor medication or prescription recommendation nor legal advice, as these activities do not fall within my scope of practice.

**Discussion of Treatment Plan:** Within a reasonable period of time after the initiation of treatment, I will discuss with you my working understanding of the problem, treatment plan, therapeutic objectives and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, my training, experience, or expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that I do not provide, he has an ethical obligation to assist you in obtaining those treatments.

**Termination:** As set forth above, after the first couple of meetings, I will assess whether I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals whom you can contact. If at any point during psychotherapy I assess that I am not effective in helping you reach the therapeutic goals, I am obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, I would give you a number of referrals that may be of help to you. If you request it and authorize it in writing, I will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified, and if he or she has your written consent, I will provide him or her with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

**DUAL RELATIONSHIPS:** Not all dual or multiple relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs my objectivity, clinical judgment or can be exploitative in nature. I will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients. Sarasota/Bradenton/Venice is a small community and many clients know each other and me from the community. Consequently you may bump into someone you know in the waiting room or into me out in the community. I will never acknowledge working with anyone without his/her written permission. Many clients choose me as their therapist because they know me before they enter into therapy with me and/or are personally aware of my professional work and achievements. Nevertheless, I will discuss with you, my client/s, the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to me if a dual or multiple relationship becomes uncomfortable for you in any way. I will always listen carefully and respond accordingly to your feedback and will discontinue the dual relationship if I find it interfering with the effectiveness of the therapy or the welfare of the client and of course you can do the same at any time

**\*\*\*CANCELLATION:** Since the scheduling of an appointment involves the reservation of time specifically for you, **a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification.** Most insurance companies do not reimburse for missed sessions.

**Complaint Procedures:** If you are dissatisfied with any aspect of my work, please inform me immediately. This will make our work together more efficient and rewarding. If you think you have been treated unfairly or unethically, by me or any other counselor, and cannot resolve this

problem with me, you may contact the Rev. Rick Howell, Th.M., Executive Director of the Samaritan Counseling Services of the Gulf Coast, 3224 Bee Ridge Road, Sarasota, Florida, 34239, at 941-926-2959. With Rev. Howell you can lodge a complaint or receive clarification of your rights. Please sign and date both copies of this form. A copy for your records will be returned to you.

#### **ADDITIONAL CONFIDENTIAL NO SUBPOENA AGREEMENT**

**Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, I agree that neither I nor my attorney nor anyone else acting on my behalf will call on Dr. Sam Miller, M.A., Th.D., LMHC, to become a witness to testify in court, communicate with child custody evaluator/s or any other proceeding or request a disclosure of the psychotherapy records.**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**I have read the above Agreement, Informed Consent, Office Policies and General Information carefully, (total 06 pages) I understand them and agree to comply with them:**

\_\_\_\_\_  
Client name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Client name (print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## Informed Consent to Assume Responsibility for Payment for Psychotherapy Services

I, \_\_\_\_\_ agree to pay for psychotherapy services and other clinical services for \_\_\_\_\_ according to the fee agreement between the therapist and the client. I understand the following terms apply to this agreement:

- Payment will be made as follows; (check one):

\_\_\_\_\_ At the time of service

\_\_\_\_\_ Within two weeks of receiving an invoice

\_\_\_\_\_ Others (specify): \_\_\_\_\_

- The fee for consultation, letter or report writing or other ancillary clinical services is \$ 60.00\_per\_\_50\_\_minute session unless otherwise specified. For more details, see previous informed consent.

- Please inform me ahead of time or as soon as you know if there are changes in your ability or willingness to pay.

- Services will be terminated if timely payment is not made as agreed to by this consent.

- Consent to assume financial responsibility for these services does not entitle the third-party payer access to confidential information unless agreed in writing otherwise by the named above patient.

- Upon your request and upon obtaining client's written permission, if appropriate, you will be provided with a bill, which is suitable for presenting to your insurance carrier for possible reimbursement. Not all conditions are reimbursable.

- This agreement supplements previous informed consents.

Signature of Client: \_\_\_\_\_

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

Signature of Therapist: \_\_\_\_\_

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

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**PERMISSION TO RECORD OR PHOTOGRAPH A  
PSYCHOTHERAPY SESSION**

I, \_\_\_\_\_ authorize Dr. Samuel Miller, LMHC to

\_\_\_\_\_ photograph

\_\_\_\_\_ audiotape

\_\_\_\_\_ videotape

\_\_\_\_\_ myself

\_\_\_\_\_ others

\_\_\_\_\_.

These recordings may be used for the following purposes (check as many as applied):

\_\_\_\_\_ Feedback to be used for psychotherapeutic intervention

\_\_\_\_\_ Supervision

\_\_\_\_\_ Research

\_\_\_\_\_ Educational

\_\_\_\_\_ Others: (Explain) \_\_\_\_\_

While the photograph or videotapes may show the faces, I Agree to not reveal names to maintain the anonymity of my own or others named above as much as possible.

Name:

(If minor) Parent's Guardian Signature:

Date:

Therapist's Signature:

Date: