Bear Creek Therapy, PLLC

Jessica Ihns, Psy.D., L.P. - owner
1178 130th Ave, Lost Nation, IA 52254

What to Expect from Counseling or Therapy

What is counseling or therapy?

Counseling or therapy is focused conversation about things you want to change in your life. Counseling is most effective when it occurs in a relationship in which trust and care are established. Friends and relatives provide a type of counseling, as do clergy, teachers, and many others. Therapists and psychologists are different from others who may offer counseling or therapy because of our capacity to maintain objectivity and privacy, as well as our extensive training in psychology and human behavior.

If I go to counseling or therapy, does it mean that there is something wrong with me?

You have sought counseling because you feel uncomfortable with some aspect of your life. You are demonstrating courage and wisdom by seeking help to gain new skills or perspectives. Some people struggle because of events in their lives. Others may struggle because of biological and situational reasons. We will work together to identify the sources of your distress and address them with the appropriate resources, including referrals to other professionals or agencies, if necessary.

What can I expect from Dr. Ihns?

You can expect someone who:

* will maintain the highest ethical and legal standards of confidentiality,
* is interested in listening to your concerns,
* is interested in helping you develop a better understanding of these concerns so that you may deal more easily and effectively with them,
* will take you seriously,
* will be open to discuss concerns,
* will be willing to answer questions about the therapeutic relationship and my approach to counseling,
* will help you explore options and discover strategies toward change,
* will help, but will not do for you what you are capable of doing for yourself.

What sort of time commitments do I need to make for counseling?

I strive to offer therapeutic treatment as efficiently as possible. The number of sessions you need will depend on the severity and nature of your presenting concerns. I can give you an estimate of how many sessions it may take to address your goals.

What can I do to benefit most from counseling?

* *Be ready to focus on a specific problem or issue*
* *Set clear and specific goals*
* *Attend your sessions regularly and take an active part in them*
* *Let me know if you will be late or are unable to attend a session*
* *Talk about what is bothering you as openly and honestly as you can*
* *Complete any tasks or homework assignments which you may be asked to do*
* *Be open to trying new or different approaches for dealing with your concerns*
* *Talk openly with me about your progress in counseling. I am most interested in you benefiting from counseling. There are may ways to provide counseling and I can modify my methods to be most effective for you.*
* *Apply your new insights and growth in your daily activities*

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Office Policy Statement

Psychological Services:

Psychotherapy involves the use of skilled interventions to resolve emotional, mental, and behavioral problems in individual, family, or group sessions. Psychotherapy has both benefits and risks. Benefits include reduced stress, better relationships, and resolution of specific problems. However, therapy might also lead you to experience stressful emotions or changes in your values or relationships. I will explain the purpose for therapeutic interventions and any potential stress I can foresee. You have a right to ask for a referral to a different therapist or agency if you are dissatisfied at any time. If you desire to change to a different therapist, you must first pay any outstanding bills. I ask that you also inform me of any concerns that you have about your therapy, as it would be optimal if we could resolve these together.

Confidentiality:

The laws of the State of Iowa require that most issues discussed during the course of therapy with a psychologist, social worker, or counselor be held confidential. Children have some of the same rights. However, parents of minor children also have a right to know the general content of therapy sessions with their children. The client (or parent of a minor child) may waive this privilege of confidentiality by signing an Authorization to Release Information form. Releases are frequently signed in order for a therapist to communicate with a physician, spouse, parent, attorney, or a previous counselor. If you learn at any time during the therapy process that information may be requested by a third party, please let me know as soon as possible.

Authorization to Release Information is *NOT* required in some circumstances:

I am legally obligated to release your Protected Health Information in several circumstances noted on the Notice of Privacy Practices Form (e.g., reports of or suspected cases of abuse, risk to self or others, for judicial or administrative proceedings, for health oversight activities, etc.)

Appointments:

It is a good idea to schedule appointments well in advance to be able to get the date and time that works best for your schedule. It is very important that you keep your appointment with me in order for counseling to be most effective. An appointment is like a contract between you and I. Once you make an appointment, please give it high priority. I understand that unforeseen circumstances or illnesses arise. However, if at all possible, **make contact at least 24 hours prior to an appointment** if you must cancel or change the time. Messages can be left by phone or email 24 hours a day.

Unless restricted from doing so by a third party payer, I may bill you for missed appointments or those canceled without 24 hours notice. The charge for a missed appointment begins at **$50.00** and may be **$100.00** for subsequently missed appointments. If there are extenuating circumstances, you may not be billed for the session. Repeatedly missing appointments will result in a charge and may result in no longer being able to be seen for therapy or psychological services. If you are charged for a missed appointment, I ask that you pay for that session before scheduling or being seen for another session.

Communication with and from the Office

The office is typically open during the published business hours. If you are unable to reach Dr. Ihns during that time, please leave a message, as she may be in session with a client. It may take up to 24 hours for a return phone call. If you are in need of immediate assistance, please call 911 or the local crisis number. Dr. Ihns sometimes also finds it necessary to contact clients by email or text messaging. There are risks involved in such communication, as unintended others may read such correspondence. If you give permission for such contact, by providing an email or cell phone number, please be advised that the information shared through these means should be limited to minimize your exposure

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to unintended releases of information to others. **Please understand, email and text messaging, as with phone messages, are not to be used in a medical or mental health emergency, as Dr. Ihns cannot guarantee immediate access or response to such messages.**

Charges, Fees, and Insurance

* If you have health insurance, part of your therapy expense may be covered. I will bill your primary insurance only (except for Medicare / Medicaid). **Remember, you are responsible for all charges and no guarantee of insurance coverage is implied by the fact that I submit your insurance claims.** This office and provider does not accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim.

* **<u>Co-payment is to be paid at the time of service.</u>**

* The person who seeks therapy, either for himself/herself or for a minor, is responsible for payment. Parents are responsible for account payments for their minor child. <u>Accounts unpaid after 90 days may be released for collection. Clients will be billed for additional costs involved and a service charge of $20 will be added to their account if their account is released to collection.</u> If no session has been scheduled for 60 days, I will understand that our therapeutic relationship has ended, unless otherwise agreed upon. If you want to continue counseling after that time, all outstanding bills will need to be paid before your file may be re-opened.

* If you or your child damages any office fixtures or furnishings, you will be responsible for the reimbursement cost of cleaning, repairing, or replacing the damaged fixture or furnishing prior to the next appointment.

*Fees:

Intake Interview	**$205**
Psychotherapy	
Individual (30 minutes)	**$85**
Individual (45 minutes)	**$120**
Individual (60 minutes)	**$170**
Family Therapy (45 mins)	**$155**
Psychological Testing	**$175 per hour of testing services**
Return Check Charge	**$30 per incident**
Consultation Fees	**$35 per 15 minute increments**

**you may be charged for email or phone call consultations, as well as completion of paperwork (such as disability, FMLA, etc.) that requires more than 15 minutes of clinical time

Court-related Activities	**$300 per hour for depositions**
	$150 per hour for travel time

I, the undersigned, have read this Office Policy Statement and agree to abide by its terms.

____ ____________________
(Client name or Parent/Legal Guardian) (Date)

____
(Printed name)

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Informed Consent Form for Treatment

Acknowledgment and Authorization Form (#1): I hereby acknowledge that I was given the opportunity to read and to receive a copy of the Notice of Privacy Practices for Bear Creek Therapy, PLLC.

Authorization to Release Information to Insurance Carrier (#2): I hereby authorize Bear Creek Therapy, PLLC to furnish my insurance carrier all information required for processing claims. Such information typically includes identifying information (client's name, date of birth, insured's name and address, etc.), diagnosis, prognosis, progress, and treatment plan. I understand that I have the right to inspect any materials released to the insurance carrier.

I also authorize my insurance carrier to release any pertinent information regarding coverage, deductible, payments made, or any other information requested to clarify claims to Bear Creek Therapy, PLLC.

I further authorize photocopies to be made of this release and for the insurance company to accept the photocopies.

This authorization shall continue in force and effect until revoked in writing by me.

Authorization to Pay Supplier (#3): I hereby authorize payment of Medical Benefits and/or Mental Health Benefits to Bear Creek Therapy, PLLC for services rendered.

Authorization for Treatment(#4): I give Bear Creek Therapy, PLLC and Jessica Ihns, Psy.D., L.P. consent to treat myself or my minor child.

Authorization for Collection (#5): I understand that if I fail to pay, the account can be turned over for collection and that I will be responsible for all costs involved.

I acknowledge and agree to the authorizations listed above (#1, 2, 3, 4, & 5).

____ ____________
Client / Insured Signature / Biological Parent or Legal Guardian — Date

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Client

Name: Last ______________________________ First __________________________ M.I.____
Address: __________________________________ City:_____________________ Zip:_______
Home Phone: (_____) _________________________ Cell: (_____) _______________________
Gender: M or F or Other Birth Date: _______________
Employer: ___________________________ Address: _________________________________
Work Phone: (_____) ____________________

Spouse

Name: Last ______________________________ First __________________________ M.I.____
Address: __________________________________ City:_____________________ Zip:_______
Home Phone: (_____) _________________________ Cell: (_____) _______________________
Gender: M or F or Other Birth Date: _______________
Employer: ___________________________ Address: _________________________________
Work Phone: (_____) ____________________

When the client is a minor, please fill in the Mother's & Father's information.

Mother

Name: Last ______________________________ First __________________________ M.I.____
Address: __________________________________ City:_____________________ Zip:_______
Home Phone: (_____) _________________________ Cell: (_____) _______________________
Birth Date: _______________
Employer: ___________________________ Address: _________________________________
Work Phone: (_____) ____________________

Father

Name: Last ______________________________ First __________________________ M.I.____
Address: __________________________________ City:_____________________ Zip:_______
Home Phone: (_____) _________________________ Cell: (_____) _______________________
Birth Date: _______________
Employer: ___________________________ Address: _________________________________
Work Phone: (_____) ____________________

Emergency Contact (not spouse or parent)

Name: _______________________________________ Relationship: ____________________
Address: _____________________________________ Phone: _________________________

Send Statement to and Responsible Party for Payment:

Name: _______________________________________ Relationship: ____________________
Address: _____________________________________ City: __________________________
Phone: _______________________________________ Zip: __________________________

Insurance:

Company: ____ Policy ID#: __________________
Insured's name: _____________________________________ Group #: __________________
Authorization #: ______________________________ Number of Sessions: _________________
Dates of Authorization: From __________ to ____________ Deductible: __________ Co-Pays: _____

I affirm that the above information is true: *Signed* _________________________________ *date:* ___

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Medical & Social History Form

Client Name: ____ Date: ______________
Address: ____
Date of Birth: ______________________ Age: ___________ Race: ____________________

FAMILY INFORMATION:

Current Living Situation:
Marital status [] Never married [] Cohabitating [] Married [] Separated [] Divorced [] Widowed
If not living alone, with whom are you now living? ____
____
If Married:
Spouse's Name: _________________________ Date of Birth: _______ Date of Marriage: _______

If this is not your first marriage, note the dates of previous marriage(s) and the name(s) of your previous spouse(s):
____
____
Describe your spouse's (or companion's) personality: _________________________________
____
Is your present relationship satisfactory? If not, specify what is unsatisfactory? ______________
____
Names and ages of your children: ____
____
Do you have special concerns about any of your children? If so, explain: _________________
____

Family of Origin:
Names, ages, and marital status of your parents: ____________________________________
____
Names and ages of brothers: ____
Names and ages of sisters: ____
Describe your family life as you were growing up: ___________________________________
____

PERSONAL INFORMATION:
Educational level achieved: Self _________________________ Spouse ______________________
If you are currently a student, list name of school and full or part-time status: ________________
____
What is your current job? ____
How long have you held your current job? _______________________________________
What other types of work have you done? _______________________________________
____
If employment problems are part of your reason for seeking counseling, specify: ______________
____
Religion: Self ______________________________ Spouse _____________________________

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HEALTH INFORMATION:

Physician: ____________________

Clinic location: ____________________

Have you previously sought counseling? If so, who did you see, why and when? ____________________

Was that counseling satisfactory? Why or why not? ____________________

What is your current reason for seeking counseling? ____________________

Do you have any major medical problems? If so, please describe: ____________________

Have you ever had a major head injury? ____________________

Do you ever lose control of your anger? If so, explain: ____________________

Have you or a family member ever been hospitalized for emotional problems? If so, please explain when, where, and why: ____________________

Are you currently taking any medications? If so, please state which ones, dosage, and how long you have been on them: ____________________

Do you have any known allergies? If so, specify: ____________________

Have you ever become dependent on any doctor prescribed medications? If so, explain: ____________________

ALCOHOL AND DRUG USE:

Have you ever felt that you ought to cut down on your drinking? ____________________

Have people annoyed you by criticizing your drinking? ____________________

Have you ever felt bad or guilty about your drinking? ____________________

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? __________

How much alcohol do you consume in a week typically? ____________________

Have you ever used any illegal drugs? If so, which ones and how often? ____________________

Has drinking or drug use caused you problems with the law or at work? If so, explain: ____________________

Have you ever sought treatment for substance abuse? If so, describe when and where and what effect it had on your use: ____________________

Has anyone in your family had problems with substance use or treatment for substance use? If so, explain: ____________________

Thank you for filling out this form. Your answers will be kept confidential.