

INFORMED CONSENT FOR PSYCHOTHERAPY SERVICES

Provider Information

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Licensed Marriage and Family Therapist (WA and CA)

1. Nature of Psychotherapy

Psychotherapy is a collaborative process intended to support emotional, psychological, and relational well-being. The approach may include discussion of current concerns, past experiences, patterns of behavior, and emotional responses.

Therapy may involve various interventions depending on your needs and goals. Progress can vary, and outcomes cannot be guaranteed.

2. Risks and Benefits

Potential benefits may include:

- Increased self-awareness
- Improved relationships
- Symptom relief
- Personal growth

Potential risks may include:

- Experiencing uncomfortable emotions (e.g., sadness, anxiety, anger)
- Temporary worsening of symptoms
- Changes in relationships

3. Voluntary Participation and Right to Withdraw

Participation in therapy is voluntary. You have the right to:

- Ask questions at any time
- Decline specific interventions
- Discontinue therapy at any time

4. Confidentiality and Its Limits

Your privacy is protected by law. Information shared in therapy will remain confidential with the following exceptions:

- Suspected abuse or neglect of a child, elder, or dependent adult
- Risk of serious harm to yourself or others
- Court orders or legal requirements
- Certain professional consultation (without identifying information when possible)

If any of these situations arise, I will make reasonable efforts to discuss this with you when appropriate.

5. Fees and Payment

This is a private-pay practice. I am not contracted with insurance panels.

- Fees will be discussed prior to the start of treatment
- Payment is due at the time of service unless otherwise arranged
- You may request a statement (superbill) for possible out-of-network reimbursement

6. Good Faith Estimate

You have the right to receive a Good Faith Estimate (GFE) of the expected cost of services. You may request this estimate before beginning services or at any time during treatment.

7. Appointments and Cancellation Policy

Sessions are typically scheduled in advance.

- If you need to cancel or reschedule, please provide at least 24 hours' notice
- Late cancellations or missed appointments may be charged the full session fee

8. Electronic Communication

Email and text messaging may be used for scheduling and administrative purposes. These forms of communication are not fully secure.

- Please do not use email or text for urgent or sensitive clinical matters
- Response times may vary

9. Emergencies

I do not provide 24-hour crisis services. If you are experiencing an emergency:

- Call 911
- Go to the nearest emergency room
- Contact the 988 Suicide & Crisis Lifeline (call or text 988)

10. Telehealth (if applicable)

If services are provided via telehealth:

- There may be risks to confidentiality due to technology
- You are responsible for being in a private location
- You may discontinue telehealth at any time

11. Professional Records

I maintain records of our work together as required by law and professional standards. You may request access to your records, subject to legal limitations.

12. Scope of Practice

Services provided are psychotherapy services within the scope of licensure as a Licensed Marriage and Family Therapist. These services do not include medical treatment or prescription of medication.

13. Medicare

If you are a Medicare beneficiary, a separate Medicare Private Contract must be completed prior to receiving services. Medicare cannot be billed for services provided under this agreement.

14. Complaints

If you have concerns about services, I encourage you to discuss them directly with me.

You may also contact the appropriate licensing board:

- California Board of Behavioral Sciences
- Washington State Department of Health

15. Consent to Treatment

By signing below, you acknowledge that:

- You have read and understand this informed consent
- You have had the opportunity to ask questions
- You agree to participate in psychotherapy services

Client Name: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____