TRANSFORMATIVE PSYCHOTHERAPY, L.L.C.
Jeannine K. Vegh, M.A., I.M.F.T.
Independent Marriage and Family Therapist #F1000006
2572 Oakstone Drive, Suite 4, Columbus, OH 43231
(614) 813-7677, transformpsych@jkvegh.com, http://jkvegh.com

Informed Consent for Psychotherapy

A. PSYCHOTHERAPY INFORMATION DISCLOSURE STATEMENT

Therapy is a relationship that works in part because of clearly defined rights and responsibilities held by each person. This frame helps to create the safety to take risks and the support to become empowered to change. As a client in psychotherapy, you have certain rights that are important for you to know about because this is your therapy, whose goal is your well-being. There are also certain limitations to those rights that you should be aware of. As a therapist, I have corresponding responsibilities to you.

B. THERAPIST'S QUALIFICATIONS

1. License: This therapist holds a license to practice as an Independent Marriage and Family Therapist, in the state of Ohio, license #F1000006.
2. Education: Highest education of therapist is a Master of Arts degree in Counseling Psychology with a minor in Somatic (Body-oriented) Psychology from John F. Kennedy University in Pleasant Hill, California.
3. Professional Associations: At this time, I am not a member of any professional associations.
4. Therapists Limitations: as a master's level psychotherapist I **cannot** prescribe or provide medication, nor perform any medical procedures.

C. THERAPEUTIC PROCESS

1. Definition: Psychotherapy is the treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth.
2. Methods Used in Treatment: I combine many techniques in treatment, depending on the person. This includes: holistic, transpersonal, somatic, CPT/PTSD, or an eclectic approach to psychotherapy. Sometimes I do include homework as well.
3. Stages of Therapeutic Process:

    a. Length of therapy will be brief and could encompass up to *ten* weeks (on average), unless the psychotherapist and client agree to extend the sessions.
    b. Initial Screening will be a 15-minute phone interview which will have already taken place prior to receiving this document.
    c. Therapy will take place in an office setting and will include conversations between client and therapist about the issue at hand, which was discussed during the initial screening process.
    d. Evaluation of therapy will occur before the *ten* weeks have concluded when the therapist will summarize and discuss what has occurred and when termination should occur.

e. Termination will occur when both the therapist and client are in agreement that therapy is no longer necessary. Special Circumstances-termination can also occur if the therapist feels that she is not properly qualified to work with the client's needs and at that time a referral will be made to a professional specialized in dealing with the client's concerns.
f. Referrals will be made to the client if necessary, during treatment.
g. Emergency Numbers and National Hotlines:
1) For a life-threatening situation, you should contact 911
2) National Domestic Violence Hotline is 1800-799-7233
3) Alcohol and Drug Hotline 1-800-821-4357
4) Child Abuse 1-800- 4-A-Child / Elder Abuse 1-800-252-8966
5) Suicide Hotline 1-800-273-8255 (TALK)
6) Helpline National Alliance for Mentally Ill; 1-800-950-NAMI

D. CONFIDENTIALITY

As a client, you have a right to confidentiality of your records. Everything that is discussed is private and confidential, with some exceptions below:

1. If you state that you are going to harm someone or are intending to harm yourself.
2. The abuse of a child or elder that is discussed will be reported to the local authorities.
3. Court Orders/testimony – if I am giving a subpoena on your behalf.
4. Insurance company if my fees are being paid by your insurance.
5. Waiver or Release of Information that you sign for me to speak to someone else in regards to your treatment. Generally, this would be a doctor. With children it would also involve parents/guardian, custodial agencies involved, school, or other professionals deemed necessary.
6. In the event of the client (s) death, the records will be shredded unless there is court involvement.
7. Therapist will share client information in consultation with another therapist or supervisor, for best practices but names will be changed in most circumstances.

E. FEES

The fees for services are listed below and are for a 50-minute therapeutic hour.

There is a NO SHOW fee of $50.00 if you do not call to cancel 24 hours in advance, this must be paid by you, insurance is not responsible if you do not show up for a session.

Cash: $120.00 (first session and $100.00 thereafter), paid for by cash, check or credit cards through Paypal the day of service.
Insurance: Please check with your insurance company to find out if I am "In Network" and what your co-pay is. If I am NOT in network ask them if you have "Out of Network" benefits. If so, ask what the cost will be to you. ***It is your responsibility to verify insurance coverage and you are ultimately responsible for payment.**
EAP: If you are using your EAP (Employee Assistance Program) you will have received an authorization number approving your sessions with me specifically. Make sure you ask them how many sessions you will receive. *If you do not know if you have an EAP or not, please call your Human Resources representative and ask them. The referral to me must come from your*

EAP directly. If I am not with them, they will offer you another therapist to choose from in your area.

F. SKYPE THERAPY

Skype therapy is not an option through insurance companies in the state of Ohio. To utilize this service, you would have to pay cash fees (see above E.) I must see you face to face before doing electronic therapy as per Ohio licensing board regulations). Skype therapy is experiential and there is not a lot of research available on this topic. American Association of Marriage and Family Therapists (AAMFT) and my state licensing organization (listed below), allow for Skype therapy to take place and I am following their guidelines which is to inform you of this and to let you know that I can only offer Skype therapy to those in the state in which I am licensed which is Ohio.

G. EMAILS FROM THERAPIST

Although emails are not shared by the therapist to anyone, they are at risk due to the fact that they can be viewed by a third party since they are not secure or encrypted. I am not responsible for unauthorized access of protected health information while in transmission (being sent by email) to the individual/client based on the individual's request. Further, I am not responsible for safeguarding information once delivered to the individual. This being stated, I am not at liberty to conduct email therapy. The emails sent by the therapist will be limited to forms necessary for the first session, resources requested by individual in session, communication from the therapist if changes in session need to be made by therapist and/or responses to you, the client's inquiries in regards to cancellations and updates to your future sessions.

H. GRIEVANCE PROCEDURES

If you have a grievance against this professional, please send your complaint to:
The State Of Ohio Counselor, Social Worker and Marriage and Family Therapist Board, 50 West Broad Street, Suite 1075,Columbus, Ohio 43215-5919. Phone: (614) 466-6462 and website: cswmft.ohio.gov.

J. WEAPONS POLICY

By consenting to treatment with Jeannine Vegh at Transformative Psychotherapy, I consent to not bring any firearm or other weapon to treatment on any occasion.

Client's Name _____

I hereby acknowledge that I have received information regarding informed consent for psychotherapy. I have had time to study the information and to ask any questions that I want to ask concerning the proposed treatment/services. I have also received a copy of this document for my own use.

_____	_____	_____
Date Signed	Client's Signature	Date of Birth
_____	_____	
Date Signed	Therapist's Signature	