

Anxiety and Behavioral Health Services\*  
Psychological Practices: Beth T. McCreary, Ph.D., LLC & Joseph P. DeCola, Ph.D., LLC  
659 High Street, Suite 202  
Worthington, Ohio 43085  
(614) 436 – 5030

### Informed Consent for Participation in Treatment

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_ e-mail: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Your psychologist is:  Dr. Joseph DeCola  
 Dr. Beth McCreary

Please read this consent form carefully, as it describes the policies and procedures followed by your psychologist. You will receive a copy of this form. The terms “psychologist” and “therapist” are used interchangeably below.

#### *Types of Service Provided by Your Psychologist:*

You will be interviewed and may be asked to fill out some questionnaires to assist the psychologist in determining how best to help you. Sometimes, additional psychological testing is conducted, and your psychologist will discuss with you the reasons for this if it is relevant. Treatment usually involves individual meetings with the therapist, but may also include group treatment and/or involving family members or significant others in some individual sessions. If you are being treated for an anxiety disorder, your therapist may sometimes arrange to leave the room or the building with you, or to meet you somewhere, in order to practice such tasks as crossing a bridge or taking an elevator with you (for example). All treatment will be conducted only with your consent.

#### *What You Can Expect from Treatment:*

Your psychologist will work with you to develop a specific, individualized treatment plan tailored to your needs. This will include a written list of specific goals that you hope to achieve in treatment. You will often be expected to work on specific tasks outside the therapy sessions. This “homework” will be decided by you and your therapist together, and might include thinking about a particular issue, reading some relevant material, writing down a log of feelings or behaviors, or practicing a particular skill, for example. The duration of treatment is different for each person and can be difficult to estimate; your therapist will address any concerns that you have about this. If you are not feeling satisfied with your treatment for any reason, you are asked to discuss this directly with your therapist. The therapist will work with you to uncover what might be preventing progress, will modify goals with you if appropriate, and will make a referral for you to (an)other professional(s) if necessary, and/or at your request. Sometimes people find that they have a temporary increase in their level of distress when beginning psychotherapy, because the process of working on personal issues can be difficult; please be aware of this.

#### *Confidentiality:*

What you discuss with your psychologist is kept confidential, or private, with some exceptions.

\*The business name “Anxiety and Behavioral Health Services” is shared by Drs. DeCola and McCreary,

each of whom maintain legally separate practices (through “limited liability companies,” or LLCs), but share certain costs to more efficiently provide services to clients. In general, you will meet with only one of these psychologists. However, these two psychologists may share information about you with each other for purposes of vacation & leave time coverage, and for clinical purposes. When you are seeing either therapist, s/he is your therapist for that session and you will be billed by that therapist. The **Notice of Privacy Practices** provides detailed information about how private information about your healthcare is protected and under what circumstances it may be shared.

*Fees for Services:*

Payments for services must be made at the time of each session. If you use insurance to pay for treatment, you are expected to pay any co-payment at the time of service. Should your insurance company refuse to remit payment for the services, you will be held responsible for paying the amount in full, as allowable by contract. If you do not pay your bill within 30 days of the date of an invoice, 2% interest may be added per month to the balance; in addition, if you default on your bill you may be held responsible for collection charges and/or attorneys’ fees. The following fees are charged for services:

Initial Assessment Session = \$150.

Therapy Session (50 minutes) = \$100.      Therapy Session (30 minutes) = \$60.

Psychological Testing Administration and Report Writing = \$100 per hour.

Group Treatment fees will be set at the time of the group.

In addition, *even if you have insurance, there are out-of-pocket fees* for writing treatment summary reports (for example, if you need a report sent to a psychiatrist or physician) and for reviewing records sent from other professionals. Insurance typically will not pay for these services, although they can require considerable time on the part of the psychologist. The fee for writing treatment reports is \$50 per hour, and for reviewing records sent from other professionals the fee is \$25 per hour.

*Cancellation policy:* You will be billed at the full out-of-pocket rate if you miss an appointment without providing at least 24 hours notice. (Insurance will not be billed; this is charged to you.)

Please initial one of the lines below and then sign to indicate that you have read and understand: 1) this Informed Consent form for participation in treatment, 2) the Notice of Privacy Practices form and how information about you may be used or disclosed, and 3) that you consent to treatment and the provisions in the Informed Consent and Notice of Privacy Practices form.

\_\_\_\_\_ I authorize my psychologist to release information about me as necessary to my insurance company for billing purposes and to receive payment directly from my insurance company. I understand that I am responsible for payment of any balance or co-pay not covered by my insurance.

\_\_\_\_\_ I do NOT authorize release of any information about me or my treatment to an insurance company. I will be responsible to pay all fees for treatment myself.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent /Legal Guardian      Date

\_\_\_\_\_  
Signature of Second Parent/Guardian      Date

\_\_\_\_\_  
Printed names of Parents or Legal Guardians or Personal Representatives (if applicable)