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INFORMED CONSENT FOR THERAPY INTENSIVES

This informed consent form provides information about the nature of intensive therapy services, the risks and benefits, and your rights as a client. Please read this document carefully and ask any questions you may have before signing.

The Nature of Intensive Therapy

Intensive therapy involves multiple, extended sessions over a short period, typically ranging from several hours per day to several days in a row. This approach aims to address specific issues more quickly than traditional weekly therapy sessions. Therapy Intensives are:

- **Time-Limited:** Therapy intensives are goal-oriented and short-term, focusing on addressing specific issues within a defined timeframe. They are not intended for ongoing or long-term mental health care.
- **Specialized Focus:** The intensive will center on therapeutic goals identified during the Pre-Intensive Interview and is not intended to address all areas of mental health.
- **Collaboration with Other Providers:** Therapy intensives may complement existing treatment. If you are under the care of another therapist, psychiatrist, or medical professional, it is encouraged that you inform them about your participation in this service.
- **Post-Intensive Follow-Up:** While the service includes a Pre- and Post-Intensive Interview, additional follow-up or booster sessions are not automatically included but may be arranged separately if needed.

Potential Benefits

- Accelerated progress in addressing specific issues.
- More concentrated focus on therapy goals.
- Potential for deeper insight and understanding of issues.
- Reduced disruptions and opportunity to improve more quickly.

Potential Risks

- Emotional discomfort due to intensive focus on issues.
- Increased fatigue due to the extended nature of sessions.
- Anxiety or pressure to reach an outcome within a short timeframe.
- Possible need for additional support between sessions.

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Scope of Therapy Intensives

Therapy intensives are designed to be a focused and time-limited therapeutic service aimed at addressing specific challenges or goals. This service includes:

- A 60-minute Pre-Intensive Interview to discuss your goals and prepare for the intensive experience.
- A 30-minute Post-Intensive Interview to process your experience and explore next steps.

What Therapy Intensives Do Not Include:

- **24/7 Crisis Support:** Therapy intensives are not equipped to provide emergency or same-day crisis interventions. In case of a crisis, please contact local emergency services or a crisis hotline.
- **Ongoing Therapy Sessions:** Therapy intensives do not replace ongoing, weekly therapy. If you require regular therapeutic support, it is strongly recommended that you work with a primary therapist who can provide consistent care. Therapy intensives are designed to complement, not substitute, long-term therapeutic care.
- **Medication Management:** This service does not include the prescription or management of medications. If medication is part of your treatment plan, please continue working with your prescribing physician or psychiatrist.
- **Treatment for Severe or Acute Conditions:** Therapy intensives are not suitable for individuals experiencing severe mental health concerns, such as active suicidal ideation, psychosis, or other conditions requiring immediate or ongoing care.

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document

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The Therapeutic Process

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

- If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
- If a client threatens grave bodily harm or death to another person.
- If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
- Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
- Suspected neglect of the parties named in items #3 and # 4.
- If a court of law issues a legitimate subpoena for information stated on the subpoena.
- If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more

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than happy to speak briefly with you but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Client Rights

1. No person will be denied services on the basis of race, religion, color, sex, sexual preference, national origin, ancestry, economic, or physical status.
2. A client has the right to participate fully in the development of his/her treatment plan and refuse parts or all of the treatment offered without jeopardizing access to other care.
3. A client has the right to refuse to be observed, taped, or to participate in research.
4. A client has the right to a full and understandable explanation of any treatment offered.
5. A client has the right to be fully and completely informed by a physician of benefits, side effects, and significant risks of all prescribed medication.
6. A client has the right to examine and receive a copy of his/her clinical record and amend the record if he/she chooses.
7. A client has the right to confidentiality of all records and communication to the extent provided by law. Requests for information (other than authorized persons) are not allowed without written consent.
8. A client has the right to file a grievance if he/she is dissatisfied with services received.

Client Responsibilities

- Attend all scheduled sessions.
- Participate actively and honestly in the therapy process.
- Communicate any concerns or issues with the therapist.

Telehealth

In the event of technical difficulties, the therapist will reach out to you by phone and can determine if continuing the session via phone is appropriate.

Acknowledgement and Consent

I have read and understood the information provided in this form. I have discussed any questions or concerns with my therapist. By signing below, I consent to participate in intensive therapy services as described.

Client Signature: _____ Date: _____

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GOOD FAITH ESTIMATE FOR THERAPY INTENSIVES

The following is information concerning fee schedules and payment procedures.

➤ Therapy Intensive Program Rates

Length	Type	Investment	What's Included
90-minute	Extended Session	\$275	
2-hours	Extended Session	\$300	
4-hours*	Intensive	\$1,200	1-hour pre-intensive interview, 2.5 hours of processing, 30-minute post-intensive interview, custom client workbook
6-hours*	Intensive	\$1,800	1.5-hour pre-intensive interview, 3.5 hours of processing, 1-hour post-intensive interview, custom client workbook
9-hours*	Intensive	\$2,700	1.5-hour pre-intensive interview, 6 hours of processing, 1.5-hour post-intensive interview, custom client workbook
*Additional hours can be added at \$200 per hour, minimum 2 hours			

HEALTH INSURANCE WAIVER

As discussed (verbally or via email), you understand that I do not accept insurance as a method of payment. By using these services, you understand you are waiving the usage of your insurance. You are, however, more than welcome to use your HSA/FSA accounts for payment.

You are responsible for understanding your own insurance benefits to include the copays and deductibles coverages available to you by choosing to work with a mental health provider

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within your insurance company's network. Those amounts may or may not be less than the fees you are agreeing to pay privately.

PROVIDER INFORMATION:

Provider Name: Courtney Bergin/Bergin Counseling & Consultation

Provider/facility type: outpatient mental health

Business mailing address: #1068, 35 Talcottville Road, Suite 10, Vernon, CT 06066

Phone: 860-245-8698

Email: bergincounseling@protonmail.com

Rendering Provider NPI: 1649811613

Taxpayer Identification Number (TIN): 33-4851929

Details of Services, Frequency, and Charges

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services,

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depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

Disclaimers

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

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To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call (800) 368-1019.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Your signature on this GFE indicates that the reimbursement decision is solely of your insurance provider and your therapist in no way guarantees or has authority in this reimbursement decision.

I acknowledge that I have read the information included, have had an opportunity to ask questions, and I agree to engage in the service(s) listed. I consent to share the information provided here.

Client Signature

Representative Signature (if applicable)

Date

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THERAPY INTENSIVE FINANCIAL AGREEMENT

Your Therapy Intensive includes:

- Customized Client Workbook
- 60-minute Pre-Intensive Interview
- __ Intensive Days (__ hours each)
- 30-minute Post-intensive Interview
- (additional intensive sessions can be scheduled at an additional fee, \$200 per hour and a minimum of 2 hours)

PRE-INTENSIVE INTERVIEW

- The Pre-Intensive Interview is scheduled for 60 minutes. The Pre-Intensive Interview and Client Workbook are used to develop resources to prepare you for your Therapy Intensive. During the session, you and your therapist will identify the goals for the Intensive and create a treatment plan to help you get there. It is recommended that you complete the customized Client Workbook and return it to your provider at least 7 days prior to the Pre-Intensive Interview. The information will be reviewed by your therapist prior to the Pre-Intensive Interview. The Intensive Session(s) are typically scheduled 2 weeks after the Pre-Intensive Interview.

INTENSIVE SESSIONS

- A single __-hour Intensive Session is a significant first step toward your therapy goals. Depending on your treatment goals, a single Intensive Session is not always sufficient. During our work together you will gain a sense of what, if anything may need attention in future therapy. Additional Intensive Sessions can be scheduled following your __-hour intensive session. Each additional 2-hour block is **\$200 per hour** which is not included in the Intensive Program fee of \$____.

POST-INTENSIVE INTERVIEW / FOLLOW UP APPOINTMENT

- A 30-minute follow-up is scheduled 2-4 weeks after your final processing session. This time is used to connect the changes that you have made in your therapy intensive program to difficult situations you anticipate encountering in the future. We may also discuss your needs following the intensive program.

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FINANCIAL RESPONSIBILITY

Insurance does not cover the cost of an intensive session. If you have insurance and choose to pursue a therapy intensive, you can agree to pay out of pocket for the intensive session(s) by signing the financial agreement. By agreeing to pay out of pocket, you understand that the intensive will not be submitted to insurance, the amount paid will not go to your deductible, and you will not be eligible for out-of-network reimbursement.

PRIVATE PAY ACKNOWLEDGEMENT

As indicated by your signature below, you understand that COURTNEY BERGIN does not accept insurance as a method of payment and does not have a contractual relationship with any insurance company. By using services at BERGIN COUNSELING & CONSULTATION you understand you are waiving utilizing insurance directly as you are acknowledging that COURTNEY BERGIN does not bill insurance directly nor communicate directly with your insurance.

If you have health insurance, and the services you are seeking are covered by your health care plan, you may be able to get the items or services described in this notice from providers who are in-network with your health plan at a lower cost. Your signature indicates your waiver of insurance benefits and agreement to pay the out of pocket fees associated with services provided.

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PAYMENT SCHEDULE

A deposit, half of the intensive program fee of \$____ is due at the time of scheduling your intensive and is non-refundable. The remaining balance is due two weeks prior to the pre-intensive interview. You may also choose to pay for the entire program (\$____) in advance. If the client is a minor, the adult accompanying the minor to the appointment is responsible for payment.

A valid credit card is needed to schedule the intensive. Payments can be made by debit or credit card. We accept Visa, Mastercard, American Express, Discover, and HSA cards.

NO SHOW & CANCELLATION POLICY

Due to the extended time commitment required for therapy intensives, a more stringent cancellation policy is in place.

In the event that you miss your intensive appointment or cancel within 2 weeks of your pre-intensive interview, your card will automatically be charged the full program fee.

NO REFUNDS

The scheduled session time is reserved exclusively for you, the Client. The non-refundable deposit can be used if the intensive is rescheduled within three months of the original date. For the 90-minute and 2-hour sessions, should you need to cancel or reschedule, you must provide 48-hours' notice, or you are responsible for the full fee. If the session concludes prior to the scheduled end time, whether by mutual agreement or at the Client's election, no prorated refund or credit will be issued.

I have read the above policies and financial agreement and agree to the above terms:

Client Signature

Date

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THERAPY INTENSIVE INSURANCE OPT OUT FORM

This form is intended for individuals who have insurance but are electing to not use their insurance for Therapy Intensives offered at A JOURNEY TO HEAL.

I understand that by signing this form, I am opting out of using my insurance and agree to pay out of pocket for the full cost of my Therapy Intensive.

I understand that by signing this form, I cannot use the payment of sessions towards my deductible and that I will not be submitting insurance claims or superbills to my insurance company on my own behalf.

I certify that I have read and understand the above statements. I certify that I am making the choice to not use my insurance for Therapy Intensives at this time.

Signature

Date

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COMMUNICATION WAIVER

I understand that text and email are not secure methods of communication.

BERGIN COUNSELING & CONSULTING will take all precautions possible to insure your privacy, however, technology breeches may happen that are out of the control of BERGIN COUNSELING & CONSULTING.

I understand this risk when I contact BERGIN COUNSELING & CONSULTING by either text message or email because I prefer the convenience of communicating this way.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature

Date

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INTENSIVE CLIENT SCREENING FORM

Thank you for taking a moment to complete this questionnaire. It helps your therapist to determine if a Therapy Intensive is right for you. Answering **'Yes'** to any of the questions below does not automatically make you ineligible for a Therapy Intensive. Your therapist may choose to follow up to gain more understanding before moving forward.

Are you actively dealing with...

- Suicidal thoughts
- Substance abuse
- An eating disorder
- Visual or auditory hallucinations
- An abusive or unsafe living environment

In the last 6 months have you:

- Attempted suicide?
- Had thoughts of suicide?
- Engaged in self-harm behaviors (i.e. cutting)?
- Overdosed?

Have you ever been:

- Hospitalized for psychiatric treatment?
- In an Intensive Outpatient Program?
- In treatment for substance abuse?
- In treatment for an eating disorder?
- Diagnosed with a mental health condition?
- Prescribed medication to improve mental health symptoms?

Do you have any health conditions?

Are you currently taking any medication? If so, what, what is it for, and what is the dosage?

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Does your family have a history of mental health conditions? If so, who and what condition?

Has anyone in your family - or anyone you know - died by suicide?

Is there anything else that may be important in determining if an EMDR Intensive is right for you?
