Kenneth Ferguson
LICENSED MARRIAGE & FAMILY THERAPIST

Informed Consent for Treatment

Process of therapy, assumed risks, & limits

Therapy can influence you in a variety of ways. You may resolve the struggle you came in to address, but a new struggle could become apparent. Your relationships could improve, but they could also change in ways you weren't expecting. Change will occur, but there is no promise that the change you experience will be expected or "positive". During the course of our meetings, we will address and discuss topics and events that will invite difficult emotions and responses. These are the risks you assume when engaging in therapy, and you are free to bring an end to our meetings whenever you feel it is appropriate.

My role in our meetings will be negotiated as we meet and decide, but there are limits to our professional relationship given my education, training, ethical and professional responsibilities. I am not able to distribute or prescribe medication. I am not trained or certified to make any judgments about the fitness or qualifications of any person or animal including, but not limited to, parenting, guardianship or the care of children; medical or physical ability to perform vocational or educational responsibilities; and/or the ability and or training to provide a service.

Confidentiality & emergency disclosure

What we discuss during our meetings is kept confidential. No contents of the meeting, whether verbal or written will be shared with another party without your explicit written consent or the written consent of your legal guardian. Despite this, Oklahoma law and the Oklahoma Board of Behavioral Health requires me to make disclosures of confidential information to appropriate parties in the following cases:

- Reasonable suspicion of child, dependent, or elder abuse or neglect
- Explicit threats and/or plans to seriously harm yourself or others
- At the request of a court order or subpoena
- A governmental agency requesting information for health oversight activities

I also may disclose relevant participant information if you are in need of emergency medical care while in my office building or in my defense if a lawsuit or complaint is filed against me.

Structure of meetings, payment, & cancellation

A standard meeting will last for an "hour" (defined as 50-60 minutes). The cost per hour is $120 to be paid at the beginning of each meeting by cash or check. Additional time scheduled or requested will

be billed at this rate ($120/hr). I reserve the right to waive or reduce any fee for service. Should you not have payment at the scheduled time of our meeting, I reserve the right to cancel the meeting. I also reserve the right to suspend or end our clinical relationship should you not pay for services rendered in a timely manner.

If you find that you need to cancel or reschedule a session, please do so prior to 24 hours before our initially scheduled session. If you are not able to do so, I reserve the right to charge the full price of the scheduled session at $120/hr. This amount will be due at the beginning of our next scheduled meeting or a bill will be mailed to your provided address should you not schedule or pay within 14 days.

Communication

You can reach me and leave a message at any time 405-862-3838. Should I not answer, I will do my best to return your call within the next business day. The therapy service I provide is an outpatient, non-emergency service. If you find yourself needing emergency services, please call 911 or the appropriate emergency service.

Documentation

I keep documentation of our meetings and they are a record of our work together. These will be maintained for 7 years after the close of our clinical relationship. Oklahoma law allows me discretion of the type of records I share with participants should the release of records cause harm. If you make a written, signed request of your records of our meetings, I will do my best to collaborate with you to meet your needs. In the case of couples, marital, or family therapy involving 2 or more consenting adults, a written and signed request needs to be made by all parties.

Minors & parents or guardians

It is the right of parents or guardians to access the records of a non-emancipated minor in therapy. While this is the case, confidentiality is one of the most important aspects of therapy, and should request for information or records of a minor be made, I reserve the right to request to meet with the parent or guardian and/or the minor to discuss the potential disclosure of their records.

By signing this form, I acknowledge that I understand the nature of a clinical relationship, the risks of therapy, nature of confidentiality, and my responsibility for payment. If the participant is a minor or has a legal guardian appointed by the court, the parent or legal guardian must sign this consent.

_____ _____

(Participant's Signature) (Date)

_____ _____

(Minor Participant's Signature) (Date)

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Participant Information

Name: _____ Date: _____

Parent(s)/Legal Guardian(s) (if under 18): _____

Address:_____

Primary Phone: _____ Alternate Phone:_____

Email:_____ DOB: _____ Age: _____

Emergency Contact: _____ Phone: _____

Gender:_____ Sexual Orientation:_____ Pronouns: _____

Marital Status: __ Never Married __ Partnership __ Married __ Separated __ Divorced __ Widowed

Referred By (if any): _____

Mental Health Information

What brings you to therapy: _____

_____

_____

How would you know therapy was successful:_____

_____

_____

Have you previously received therapy or psychiatric services: ___Yes ___ No If yes, how long: _____

Did you feel it was successful: ___Yes ___ No Why or why not: _____

_____

_____

Current psychiatric medication: _____

Past psychiatric medication: _____

Do you act on impulses you struggle to control: ___Yes ___ No If yes, to what: _____

_____

Witness to or victim/survivor of traumatic event(s): ___Yes ___ No If yes, what occurred and when: _____

_____

Familial history of mental health struggles: _____

_____

_____

Economic, Education, & Social Information

Employed: ___Yes ___ Self ___ Looking ___ No Household Income: _____

Employer(s) / Job Title(s): _____

Highest Education Level: _____ Area of Study: _____

Current School: _____ Planned Graduation: _____

Race: _____ Cultural / Ethnic Heritage: _____

Religion / Denomination / Spirituality: _____

Who do you live with (names & ages): _____

_____

How would you describe your family growing up: _____

_____

_____

Drink alcohol: ___Yes ___ No If yes, how much and how often: _____

Smoke/vape nicotine: ___Yes ___ No If yes, how much and how often: _____

Non-prescribed or illegal substance use: ___Yes ___ No If yes, type(s): _____

Has anything changed in your life recently: ___Yes ___ No If yes, what & when: _____

_____

_____

How many close relationships do you have: _____ Do you feel you need more: ___Yes ___ No

Hobbies & Interests: _____

_____

Physical Health Information

How would you describe your current health: _____

Current health struggles: _____

_____

Current prescription medication: _____

Sleep struggles: ___Yes ___ No Eating struggles: ___Yes ___ No Sexual struggles: ___Yes ___ No

PCP or family doctor: _____ Last seen month/year: _____

Family history of illnesses and diseases: _____

_____

_____

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REQUEST FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ AUTHORIZE: Kenneth Ferguson, LMFT
(name of participant)

2915 N Classen Blvd, Ste 120-B

Oklahoma City, OK 73106

TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment (but not to include any financial or claims-related identifiers including, but not limited to, credit card numbers, insurance plan numbers, diagnosis codes, or procedure codes.)

TERMINATION

O This authorization will terminate _____ days after the date listed below.

OR

O This authorization will terminate when the following event occurs: _____

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

I understand that Kenneth Ferguson, LMFT makes available to me the following means of communication that are designed to be secure and to maintain confidentiality, and I still choose to request and authorize the above-named non-secure means:

- Telephone

_____ _____
(Participant's Signature) (Date)

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Electronic Payment Communications Disclosure

If you wish, you may pay fees electronically – through funds transfer or using a payment card – using the Square service **please be aware of the following:**

I, Kenneth Ferguson, have a duty to uphold your confidentiality, and thus I wish to make sure that your use of the above payment services is done as securely and privately as possible.

After using any of the above services to pay your fees, that service may send you receipts for payment by email or text message. These receipts will include my business name, and would indicate that you have paid for a therapy session.

It is possible the receipt may be sent automatically, without first asking if you wish to receive the receipt. I am unable to control this in many cases, and I may not be able to control which email address or phone number your receipt is sent to.

So before using one of the above services to pay for your session(s), please think about these questions:

- At which email address or phone numbers have I received these kinds of receipts before?
- Are any of those addresses or phone numbers provided by my employer, school, or other institution? If so, that entity will most likely be able to view the receipts that are sent to you.
- Are there any other parties with access to these addresses or phone numbers that should not be seeing these receipts? Would there be any danger if such a person discovered them?

In addition to these possible emails or text messages, payments made by credit card will appear on your credit card statement as being made to *Kenneth Ferguson LMFT, PLLC*. Please consider who might have access to your statements before making payments by credit card.

Health Savings Accounts and Flexible Spending Accounts

If you are using a Health Savings Account (HSA) or Flexible Spending Account (FSA) payment card, please be aware that even if your payment goes through and is authorized at the time that we run your card, there is a possibility that your payment could later be denied. In the event of this happening, you are responsible for ensuring that full payment is made by other means.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of the potential exposure of my protected health information. I understand that I am not required to use the Square service in order to receive treatment. I also understand that I may cease to use it at my own discretion

_____ _____

Participant Signature *Date*