

**Informed Consent for  
Behavioral Medicine Services**

**Note:** You should read this form. It provides important information about your treatment and Associated Neurologists, P.C. operations. It also contains certain agreements in conjunction with your treatment.

**No Alterations/Failure to sign:** This form may not be altered in any manner. Please understand that we cannot track individual changes, and therefore cannot honor cross outs or new language. If you have questions about this form, please discuss them with your provider, who will answer them to the best of their ability. Please also be aware that, if you do not sign this form, and this results in a refusal of your insurance company, managed care organization or any other third party payor to provide coverage and/or pay your bill, you will be personally responsible for the entire unpaid portion of your bill.

---

**Welcome to Behavioral Medicine**

Behavioral Medicine is an inter-disciplinary field that focuses on the biological, psychological, and social factors of a person's medical illness, overall health, and functioning. Behavioral Medicine providers are experienced Clinical Psychologists who are highly knowledgeable about medical illnesses. This specialty focuses on the mind-body connection and the complex relationship between psychological and medical issues. Our providers rely on non-medication based treatments such as cognitive behavioral ("talk") therapy, relaxation skills training, problem solving and biofeedback. A personalized approach to match your needs is offered to each patient to help address several common issues including, but not limited to, stress, relationship conflicts, physical health, caregiver stress, family /social/work concerns, anxiety and depression.

**SERVICES OFFERED:**

• **Evaluation Services:**

The purpose of the first one to two sessions with our office is to assess your current level of stress, symptoms and complete a diagnostic evaluation (e.g. interview and or psychological testing). After this evaluation treatment recommendations will be offered to you and a report may be sent to your referring doctor. If follow up appointments are recommended with our office you may be scheduled with a different provider in our office based on your specific circumstances (i.e. your schedule availability and the specialties of our providers). Depending on the reason for your referral to us, you may only be seen for an evaluation (as in the case of pre surgical psychological evaluations for weight loss surgery, spinal surgeries or if you require a treatment service that we do not offer).

• **Individual Psychotherapy:**

After an evaluation it may be recommended that you return to our office for a brief period of counseling sessions.

• **Goals of treatment:**

Whatever your goals for counseling, they will be set by you according to what you want to work on during your time here. Some patients wish to work towards long term goals such as improving quality of life and learning to live with mindfulness. Other goals may be more immediate such as decreasing anxiety and depression symptoms, developing healthy relationships, improving coping skills, or changing unwanted behaviors. Our providers will make suggestions on how to reach these goals and help guide this process.

• **Risks/Benefits of Counseling:**

Counseling is a very personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Progress may happen slowly. Counseling requires a very active effort on your part therefore in order to be most successful you will have to work on things we discuss outside of sessions. There are many possible benefits to counseling including: helping you develop coping skills, make behavioral changes, reduce symptoms of emotional distress, improve the quality of your life, learn to manage anxiety, stress, anger, and how best to cope with medical illnesses.

**Associated Neurologists, P.C.  
Behavioral Medicine Department**

• **Group Psychotherapy and Education Workshops:**

Our office routinely offers caregiver support groups to provide education and support for those who are caring for a loved one diagnosed with dementia. Additionally, we offer a variety of educational workshops on behavioral medicine topics such as headache management. Available groups are advertised in the waiting room when they are being offered.

• **Testing Services:**

If you were referred to Behavioral Medicine for psychological testing these evaluations will occur over 1-2 sessions including a feedback session explaining the results of our findings. These tests are not the same as neuropsychological tests (which focuses on a person's ability to think, learn and remember). Psychological tests focus on aspects of personality and symptoms of mental health disorders to aid in making a formal psychological diagnosis. We routinely offer testing sessions to diagnose or rule out Attention Deficit / Hyperactivity Disorder, Autism Spectrum Disorders, anxiety, depression, psychotic disorders, Post traumatic Stress Disorder and Post-concussion syndrome. Testing sessions also include a comprehensive interview with the patient and concludes with a summary of treatment recommendations to address the problems identified during your evaluation and testing session.

**CONFIDENTIALITY:**

**Limits to confidentiality:**

Your therapist will make every effort to keep your personal information private at all times. In all cases therapists and staff in this department adhere to all privacy standards as governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that guards the privacy of your protected health information. All communications with your psychologist are privileged and will not be disclosed to others except when you waive this privilege and request us to disclose your records.

There are some limitations to confidentiality to which you need to be aware. Your therapist may consult with a supervisor or other professional therapist in order to give you the best service. In this case your therapist will not use identifying information such as your name. Additionally, your health information can also be disclosed in the following situations:

- If your therapist has reason to believe that you may harm yourself or others (*Pursuant to Section 52-146 of the Connecticut General Statutes*).
- If your therapist has reason to believe that you are involved in or have knowledge of abuse or neglect of a child (*Pursuant to Section 17a-101 of the Connecticut General Statutes*); or abuse, neglect, or exploitation of a person who is elderly (*Pursuant to Section 17b-451 of the Connecticut General Statutes*), a resident in a long term care facility (*Pursuant to Sec. 17b-407 of the Connecticut General Statutes*) or has an intellectual disability (*Pursuant to Section 46a-11b of the Connecticut General Statutes*).
- If ordered to disclose your records by state, federal court, subpoena or to comply with a police investigation.
- When your health information is required in order to file claims and receive payment for services rendered from your private insurance carrier, Medicare, or to allow a collection agency to seek payment for services.
- When necessary in order to remain in compliance with Medicare and insurance company reporting requirements (e.g. with the insurer or agency used to gather and report this data).

**Confidentiality in Groups:**

Please note, we require that all group members maintain the confidentiality of group members and what is discussed in group. Be aware that your therapist cannot guarantee that other group members will maintain your confidentiality. However, your therapist will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your therapist also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

**Associated Neurologists, P.C.  
Behavioral Medicine Department**

**Release of Your Records/ Office Notes from this Department:**

If you wish to have your health records released, you will be required to sign a consent form before such information will be released. Please note requests for release of therapy records **must include specific language on the release form stating that you are specifically giving permission to release psychiatric records** or the request will be denied. Additionally, under some circumstances your therapist may choose **not** to release these records directly to you and instead can choose to release them to another provider or mental health professional (*Pursuant to Section 20-7c(d) of the Connecticut General Statutes*).

**OFFICE POLICIES:**

**Same day / less than 24 hour notice cancellations:**

If you need to cancel or reschedule an appointment we ask that you contact our office as soon as possible but **no later than 24 hours before your scheduled appointment time**. Appointments cancelled within this timeframe incur a \$50 fee. One exception to the 24 hour rule is if you are sick in which case no cancellation fee will apply. Please note, certain conditions such as repeated cancellations or not arriving for appointments without contacting our office may require discontinuation of your treatment. In the event this happens referrals for providers within the community will be given to you.

**Session length and Duration of our Brief Counseling Treatment Services :**

Sessions are scheduled for **45 minutes**. They are expected to begin promptly, and end at the scheduled time. Although it is understood that there may be instances when you arrive late for a session, late arrival will not extend the scheduled ending time for the session and a late arrival may mean that your provider may not be able to see you. Your therapist as well is also expected to be on time, and will offer appropriate remedy if late, such as making the time up at a future visit.

The duration of time you attend counseling here is dependent upon a number of factors including your goals, timeframe, rate of progress, etc. It should be noted that our practice specializes in **brief counseling** methods intended to help patients adjust to medical diagnoses and symptoms. Patients are typically seen for 6 months or shorter although some may be seen for as long as 12 months. If additional counseling is needed beyond this timeframe your therapist will work with you to offer you appropriate treatment referrals to alternate providers. Possible exceptions are patients who are seen here on an intermittent basis such as caregivers. If this situation may apply to you please discuss this with your therapist on an individual basis.

**Patients Seeing More than One Therapist:** With rare exceptions we ask that patients seeking counseling from our providers do not have another therapist while they are in therapy here. In order to provide consistent treatment and advice that is not in conflict with other treatment recommendations it is best to avoid having multiple therapists. This does not however apply to seeing other professionals. It is acceptable for patients to also have a psychiatrist or couples / marital/ family counselor while seeing a therapist here.

**Communication with our Office:**

As part of your responsibility as a patient in this department **we expect to be in contact with you directly** to make your appointments (as opposed to having a spouse, parent or other person call on your behalf). While we understand that some patients rely on others for their transportation we feel it is important for your growth and full participation in therapy for you to contact us on your own behalf. This will also ensure the highest level of privacy for you and your treatment. ***If another person calls on your behalf to make an appointment for you or discuss your treatment here our staff may not be able to speak with them.***

Additionally, please note that due to staffing availability within the department and for the privacy of our patients we cannot accommodate walk-ins for questions or appointments.

**Associated Neurologists, P.C.  
Behavioral Medicine Department**

**After Hours Policy/Procedure:**

If you need to contact your therapist for a non-urgent matter you are encouraged to discuss matters with your therapist during your sessions. You may also leave a non-urgent message on the confidential voice mailbox for Behavioral Medicine at 203-748-2551 ext. 332. ***If you are in crisis, please call the 24-hour crisis hotline at***

***1-888-447-3339 or 911. If your emergency concerns a minor child you may also call mobile crisis by calling 211.*** Please note, Associated Neurologists is not a crisis facility and will not be held responsible for any damages occurring as a result of unmet crisis or acute care needs.

**Our Responsibility to You:**

Our promise to you is to conduct our work with respect, dignity, and compassion in the delivery of all of our services to you. At all times we avoid harm, any foreseeable conflicts of interest and we protect your health information to the strictest level possible. If at any time you have concerns or complaints you are encouraged to speak with your therapist about it. If your concerns are not resolved you can contact our office manager and privacy officer (Wendy White) at 203-748-2551 ext. 309.

**Termination of Therapy:**

In general, termination of therapy is a mutually determined decision based on the progression of treatment. Please note:

- Behavioral medicine patients (or the parents if the patient is a minor) have the right to terminate therapy at his/her discretion at any time. Upon either party's decision to terminate therapy, the therapist will generally recommend that the patient participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both parties an opportunity to reflect on the work that has been done. The therapist will also attempt to ensure a smooth transition to another therapist by offering referrals to the client.
- Pursuant to the *APA Ethical Standards 10.10(a)* Psychologists can terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service.
- Providers in this department have the right to terminate therapy with you immediately if you threaten violence, verbally or physically harass us or our families.
- ***Failure to arrive for two consecutive sessions and or failure to make contact with our office or respond to our attempts to reach you for 30 days automatically ends your therapy treatment*** with your behavioral medicine provider. Possible exceptions are patients who have made previous agreements with their therapist to check in on a less frequent but longer term basis (e.g. caregivers).
- Other reasons for termination include, but are not limited to, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, patient needs that are outside of the therapist's scope of competence or practice, or if the patient is not making adequate progress in therapy.

Regarding therapy that has terminated, it does not prevent you from recontacting our office in the future to return for treatment. We recognize that treatment needs change over time and you may want to return in the future for the same or a different concern. Please do not hesitate to contact us and restart treatment here in the future.

**Acknowledgment.** I acknowledge that I have read and understand this document, have received acceptable answers to all my questions regarding services I will receive at this office and have been offered a copy of this document. My consent is given voluntarily and without coercion. I understand that I may discontinue treatment in the behavioral medicine department at any time and that I may refuse to participate in any particular or specific treatment services offered to me without penalty. Furthermore, I understand that this consent form relates to my relationship and services I am seeking with providers in the Behavioral Medicine Department and not Associated Neurologists, P.C. as a whole. I understand this document covers matters specific to the Behavioral Medicine department and information regarding my HIPAA privacy rights and the financial policies of Associated Neurologists are covered under separate documents.

**Associated Neurologists, P.C.**  
**Behavioral Medicine Department**

Please initial one: \_\_\_\_\_

**I AGREE** to all of the terms outlined in this document and understand I will be asked to sign this document once per year or sooner if substantial administrative changes are deemed necessary sooner.

\_\_\_\_\_

**I DO NOT AGREE** to all of the terms outlined in this document. I understand that failing to agree with the terms of this agreement I may not be accepted as a patient in the behavioral medicine department of Associated Neurologists. In this case we will provide you with a list of alternate providers and guidance on how to locate another provider for your treatment.

\_\_\_\_\_  
**Client Signature**

Date \_\_\_\_\_

**(If Client is a Minor):**

**Minor Name** \_\_\_\_\_

Date \_\_\_\_\_

**Parent or Guardian Signature** \_\_\_\_\_

**Associated Neurologists, P.C.  
Behavioral Medicine Department**

**ADDENDUM**

**INFORMED CONSENT FOR PSYCHOTHERAPY  
WITH MINOR CHILDREN (UNDER 18)**

If you are under the age of 18 it is your choice if you want a parent to be present for a portion of your evaluation or counseling sessions here. Many people in this age group choose to have their parent or guardian present for a portion of their evaluation and sometimes a few minutes of your counseling session (on an as needed basis) in order to give your therapist a window into how things are going for you at home and school. Parents are also helpful by providing family history and knowing what you are working on in therapy so that they can support your therapy goals in between sessions.

**Confidentiality With Regard To Minors:**

*Pursuant to Sec. 19a-14c* of the Connecticut general statutes, outpatient mental health treatment can be delivered to minors (patients under the age of 18) without parental consent under certain circumstances. Please discuss this with your provider if you do not wish for your parents or guardian to accompany you to counseling at this office. Please note however that if you do not inform your parents or guardian that you are seeking treatment here you will be responsible for the payment of therapy services instead of your parent or guardian. Your therapist will discuss with you the limitations, procedures, and implications with regard to your records and treatment progress.

**Communicating with your parent(s) or guardian(s):**

Except for situations such as those mentioned above, we will not tell your parent or guardian specific things you share with our providers during your private therapy sessions. This includes activities and behavior that your parent/guardian may not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then we will need to use our professional judgment to decide whether you are in serious and immediate danger of being harmed. If we feel that you are in such danger, we will communicate this information to your parent or guardian with your participation and our guidance.

You can always ask your therapist questions about the types of information we have to disclose. You can ask in the form of “hypothetical situations,” in other words: “If someone told you that they were doing \_\_\_\_\_, would you tell their parents?”

Please know, even if your therapist has agreed to keep information confidential – to not tell your parent or guardian – we may believe that it is important for them to know what is going on in your life. In these situations, we will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, we may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

**Communicating with other adults:**

**School:** We will not share any information with your school unless we have your permission and permission from your parent or guardian. Sometimes we may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for us to give suggestions to your teacher or counselor at school. If we want to contact your school, or if someone at your school wants to contact us, we will discuss it and ask for your written permission. A very unlikely situation might come up in which we do not have your permission but both I and your parent or guardian believe that it is very important for us to be able to share certain information with someone at your school. In this situation, we will use our professional judgment to decide whether to share any information.

**Associated Neurologists, P.C.  
Behavioral Medicine Department**

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a therapist. We will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time we will share information with your doctor even if we don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

**Acknowledgment.** I acknowledge that I have read and understand this document, and have received acceptable answers to all my questions regarding services I will receive at this office. My consent is given voluntarily and without coercion. I understand that I may discontinue treatment in the behavioral medicine department at any time and that I may refuse to participate in any particular or specific treatment services offered to me without penalty. Furthermore, I understand that this consent form relates to my relationship and services I am seeking with providers in the Behavioral Medicine Department and not Associated Neurologists, P.C. as a whole.

Please initial one:

\_\_\_\_\_ **I AGREE** to all of the terms outlined in this document and provide my assent for treatment.

\_\_\_\_\_ **I DO NOT AGREE** to all of the terms outlined in this document. I understand that failing to agree with the terms of this agreement I may not be accepted as a patient in the behavioral medicine department of Associated Neurologists. In this case we will provide you with a list of alternate providers and guidance on how to locate another provider for your treatment.

**Minor's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(assent for treatment)

**Parent or Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(consent for treatment)

**Associated Neurologists, P.C.  
Behavioral Medicine Department**

**ADDENDUM**

**INFORMED CONSENT FOR  
BIOFEEDBACK SERVICES**

**Biofeedback Services**

Biofeedback sessions are offered to help teach patients relaxation skills in order to decrease anxiety and muscle tension, improve focus and attention, and increase your mind / body awareness. Biofeedback is a non-invasive procedure and does not use any needles, skin penetration, or other invasive procedures. The Association for Applied Psychophysiology (AAPB), the Biofeedback Certification International Alliance (BCIA), and the International Society for Neurofeedback and Research (ISNR) define biofeedback with the following standardized description:

*"Biofeedback is a process that enables an individual to learn how to change physiological activity for the purposes of improving health and performance. Precise instruments measure physiological activity such as brainwaves, heart function, breathing, muscle activity, and skin temperature. These instruments rapidly and accurately "feed back" information to the user. The presentation of this information — often in conjunction with changes in thinking, emotions, and behavior — supports desired physiological changes. Over time, these changes can endure without continued use of an instrument."*

The type of biofeedback offered in our department is called heart rate variability (HRV) biofeedback. During HRV biofeedback patients are instructed on how to perform relaxation techniques (e.g. deep breathing, visual imagery, progressive muscle relaxation, etc.). A pulse monitor is attached to your finger or ear during the session to collect physiological data (i.e. pulse) which provides "feedback" to the patient and therapist about how your body is responding to the relaxation training (i.e. as tension and stress decreases in the body your pulse and "stress" scores visually depicted in the EMWave program will also decrease). A full orientation of the program will be provided to you and an introductory practice session will allow you to see the program and test its potential benefits before deciding if you wish to incorporate this tool into your therapy sessions.

**Possible benefits of biofeedback include:** A reduction of Anxiety, Depression, Anger, pain, Blood Pressure, Dizziness, Vertigo, IBS, Tics; as well as an increase in: Focus, Attention, Concentration, Mental Dexterity, Short Term Memory, and General Well-Being.

**Possible risks:** It is possible that biofeedback may exacerbate emotional problems, at least temporarily, during the biofeedback training sessions. Additionally, some clients may become drowsy while learning to relax. Research suggests that while most people gain considerable benefits from biofeedback training, there is no guarantee that you will.

**Contraindications:** In general, there are a few situations/disorders for which relaxation skills training may be contraindicated. These include: acute, severe or unstable medical illness, disorders which involve severe, unstable autonomic nervous system or metabolic functions. Caution is also recommended in patients with severe impairments of memory, of attention or in unstable neurological conditions such as seizure. You agree that you will notify our department immediately if any of these conditions apply to you. In certain medical situations we may require a doctor's approval prior to doing biofeedback.

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
Date

**If Client is a Minor:**

**Minor Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent or Guardian Signature** \_\_\_\_\_