INFORMED CONSENT FOR TREATMENT: INTEGRATIVE MEDICINE ACUPUNTURE AND PSYCHOTHERAPY

This holistic approach is ideal for people who want to:

- Reduce stress, anxiety, depression and their physical manifestations
- Experience results that are sustainable over time
- Achieve optimal wellness and inner balance

When patients receive both acupuncture and psychotherapy, research has shown that people experience:

- Greater ability to make progress in therapy – to engage with, release, and heal core-level mental and emotional suffering
- Faster relief from common associated physical symptoms such as insomnia, headaches, muscle pain and digestive issues
- Smoother transitions off of SSRIs and other medications

Acupuncture

- *releases core-level tension* at the level of the body and energy system
- creates a *physical experience of emotional peace* and inner balance
- provides *physical and chemical ways to maintain inner balance* through Chinese herbs and dietary recommendations

Psychotherapy

- *increases self-awareness* at the level of the body, emotions and thoughts
- helps the client *experientially understand the connections* between past trauma, thought patterns, challenging emotional states and negative behavior patterns
- provides a safe, empathic space where the client can *consciously heal past traumas*, thus creating peace and balance in the present moment

When these techniques are used together, clients are able to both consciously understand and heal their mind, emotions and behavior (psychotherapy), while releasing the core-level physical and energetic tension that has accumulated due to past trauma (acupuncture). Acupuncture offers a natural way to heal the physical side effects of stress, anxiety and depression, while psychotherapy helps the client heal these conditions at their root.
This mutually reinforcing support allows clients to sustain the intensive and very challenging efforts needed to heal from past traumas and current stress, anxiety and depression. The healing of mind and body is the result.

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INFORMED CONSENT FOR TREATMENT:
(CONTINUED)

Confidentiality: Information obtained during counseling sessions will not be disclosed to any outside persons or agencies without your written permission, except when required by law:

1. reasonable suspicion of abuse of children or elderly persons
2. client(s) present a serious danger of violence to another
3. client(s) may be harm to him/herself unless protective measures are taken

I understand that information discussed in therapy is for therapeutic purposes and is not intended for use in any legal proceedings, therefore I agree not to subpoena Jennifer Hill to testify on my behalf in a court action. I have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with Jennifer Hill.

Payment: I understand that as private paying client, I am expected to pay at the time of counseling services by credit card, cash, or check. The standard fee is $120.00 per session, unless special arrangements have been approved. I agree to pay the agreed upon amount of $______ for all services provided by Jennifer Hill at the end of each session. Any check returned for insufficient funds will be assessed a $35 fee. I understand that if we chose to pay with a credit card, then we must also pay 2.75% processing fee.

_____ **(initial)**

Appointments: Sessions consist of 50 minutes made in advance starting and ending on time. If I arrive late, the session will still cost full price and ends at the pre-arranged time. Cancelations must be provided at least 24 hours prior to the scheduled appointment. I agree to pay $50 no-show fee if notice is not given within 24-hour timeframe. I will call Jennifer Hill at (760) 458-1600 at least 24 hours in advance and leave a message in order to avoid being charged. Lateness or cancellations made by the therapist will be rescheduled. ______ **(initial)**

Please initial the following correspondence options to authorize Jennifer Hill for future communication regarding appointments, billing issues, or other pertinent information regarding my treatment.

☐ Voice messages at: ___________________

☐ Text messages at: ____________________

☐ Email messages at: __________________________

Email, texting, and other forms of internet-based communication are non-secure and non-confidential. If I send emails and texts to Jennifer Hill with a response requested, I am willing to accept the risks.

Emergencies:

In the event of an emergency call 911 or (888)724-7240. The therapist will discuss emergency planning with you and most telephone calls made to Jennifer Hill will be returned during business hours on weekdays and most Saturdays.

By signing below, I agree to the policies entailed on pages #1, #2 and #3. I also agree to receive mental health services from Jennifer Hill MS, LPCC and accept full responsibility for payment for such services.

______________________________ ______________

Client Signature Date

______________________________ ______________

Counselor Signature Date