

Outpatient Psychiatry and Counseling Clinic Guidelines for Treatment

Welcome to our clinic! We are very pleased you have chosen us to participate in your care. Please read the following information and ask our staff if you have any questions or concerns.

Informed Consent for Treatment

Our treatment center offers outpatient psychiatric and counseling services for individuals and families.

- Psychiatric care is available for those aged 14 and older.
- Therapy services are provided for children (5 and older), adolescents, and adults.
- We collaborate with clients on goals for treatment and provide a variety of interventions.
- We utilize a team approach and have a psychiatrist, a licensed clinical social worker, and a clinical psychologist on staff.
- We consult as a team as needed on individual cases and may make a referral for more intensive or specialized treatment if we feel this would best meet your needs.

Confidentiality of Information and Exceptions to Confidentiality

In general, the law protects the confidentiality of all communications between a patient and a therapist/psychiatrist.

- The content of treatment sessions and information collected from you will only be available to the clinic staff
- A patient's personal information can only be shared with individuals outside the clinic with the patient's written consent.
- Individual cases, including information shared by patients, may be shared when necessary by KSB Hospital's Outpatient Psychiatry and Counseling Clinic Department Director and among other treatment providers.

There are several exceptions and limits to confidentiality that are important for you to know.

- If the provider believes that a child, elderly person, or disabled person is being abused, he/she is required to file a report with the appropriate state agency (i.e., Illinois Department of Child and Family Services).
- If the provider believes that the patient is at imminent risk of threatening serious bodily harm to her/himself or to another person, the provider is required to contact the appropriate authorities or individuals (i.e., seeking appropriate hospitalization, contact family members or others who can help provide protection, notifying the potential victim, notifying police.)

- The provider is also required to release confidential information if ordered by the court of law.

Attendance Expectations

Based on a patient's treatment plan, recommended frequency and duration of sessions are discussed. We have created guidelines and expectations for attendance in our clinic; at therapist discretion we may not be able to continue to treat you in the clinic if you have continued missed appointments.

- In order to ensure that treatment works as well as possible, it is important that you keep your scheduled appointments.
- Chronic tardiness or inconsistent attendance can interfere with treatment success.
- After one missed appointment (you do not show or cancel your scheduled appointment), we will call or send a letter inviting you to set up another appointment.
- After two missed appointments, we will notify you by letter that you need to set up a Care Meeting with your provider to discuss and problem solve the barriers for coming to treatment and decide if you want to continue therapy or stop.
- After three missed appointments, then you may be notified by letter that you need to contact the office within 10-days or your provider may discharge you from the clinic.

Fees and Payment Policies

We are contracted with various insurance panels to provide mental healthcare to patients.

- You are responsible for contacting your insurance provider and finding out what's your coverage for mental health outpatient services is.
- You are responsible for any costs that are not paid for by your insurance.

Hours and Emergencies

- Hours are by appointment only to be scheduled by calling the office at 815-285-5638.
- We are not designed to provide emergency services or ongoing crisis management.
- If you or your child have a mental health emergency and require immediate assistance, please call 911 or go to the nearest hospital emergency room.
- If you believe you need therapy that provides 24-hour crisis management, please discuss this with your therapist and they will help you find a referral to services that can best meet your needs.

Your Rights and Responsibilities

Rights

- To be treated, with dignity and respect, as an individual who has feelings, preferences and needs
- To be fully informed of your rights and responsibilities as a client in this facility;
 - To the confidentiality and privacy of your treatment records, as protected by federal and state statutes;
 - To know what records will be kept and who will have access to them;
 - To know what the problem is from the perspective of the counselor in clear language that you can understand;
 - To participate in selecting goals and objectives of your treatment;
 - To review, upon request, your individualized treatment plan outlining your recommended treatment program;
 - To know alternative methods of dealing with your problem(s);
 - To refuse any counseling intervention except in a situation where such intervention is necessary to prevent serious physical harm to yourself or others;
 - To be informed of the consequences of refusing counseling or a specific counseling intervention;
 - To complete access to services of The KSB Outpatient Psychiatric and Counseling Clinic regardless of religion, race, ethnic background, sexual preference, or handicapping conditions;
 - To know how many counseling sessions are to be expected;
 - To know how much the intervention will cost;
 - To file a grievance as a formal notice of dissatisfaction regarding this service and the actions or omissions of staff; and
 - To know in advance about termination of services.

Responsibilities

- To actively participate in the counseling process
- To inform your counselor of any changes in your situation that would affect your treatment in any ways.
- To give accurate and complete information to the staff so they can effectively assist you in your recovery;
- To respect the rights and confidentiality of other clients and staff; and
- To regularly make and keep appointments with your counselor or give 24- hour notice if you are unable to keep an appointment.

**PATIENT HEALTH QUESTIONNAIRE-9
{PHQ-9}**

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every Day
	0	1	2	3
1. Little interest or pleasure in doing things.				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				

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TOTAL SCORE:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- | | | | |
|---|---|---|--|
| Not difficult at all
<input type="checkbox"/> | Somewhat difficult
<input type="checkbox"/> | Very difficult
<input type="checkbox"/> | Extremely difficult
<input type="checkbox"/> |
|---|---|---|--|

GAD -7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every Day
	0	1	2	3
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so rest less that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid, as if something awful might happen				

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TOTAL SCORE:

Scoring GAD- 7 AnxietySeverity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."

GAD-7 total score for the seven items ranges from 0 to 21.

- 0-4: Minimal anxiety
- 5-9: Mild anxiety
- 10-14: Moderate anxiety
- 15-21: Severe anxiety

**KSB Outpatient Psychiatry & Counseling Department Informed
Consent for Teletherapy Services (March 2020)**

There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.

- Confidentiality still applies for teletherapy services. Nobody may record the session without the permission from the others person(s).
- You agree to use the video-conferencing platform selected for our virtual sessions and the therapist will explain how to use it.
- You need to use a webcam or smartphone for teletherapy sessions.
- Choose a quiet, private space free of distractions (including cell phone or other devices) during the session.
- All individuals present during teletherapy must be in the camera view.
- Use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the provider in advance by calling our office at 815-285-5638.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
- Parent(s)/legal guardian(s) must give permission for minor children to participate in telepsychology sessions and provide their contact information to provider.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- Your provider may determine that due to certain circumstances, teletherapy is no longer appropriate and need to suspend the sessions and determine another plan for treatment.
- For legal reason, you must physically be in IL to participate in teletherapy with a KSB provider.

Patient signature and date: _____

Teletherapy Agreement
Outpatient Psychiatry & Counseling Department KSB
Hospital

The purpose of this document is to ensure that all participants have the same understanding of teletherapy and how treatment will be provided. Before we start, it is important that all parties agree with the following information. This will help to make sure the therapeutic relationship and process proceeds smoothly.

- o I have reviewed the teletherapy informed consent and was provided with an opportunity to ask and have all questions answered.
- o KSB teletherapy providers are licensed in the state of Illinois and agree to abide by the state and federal professional regulations that guide practice in therapeutic interventions, including teletherapy.
- o Therapists conduct these services from either their home or clinic office in Dixon, IL. It is the therapist's obligation to create a workspace and take all necessary measures to ensure that your sessions are confidential and not being overheard, when the therapist is working at home.
- o Therapy sessions are scheduled by office staff or the therapist, and if you need to cancel or reschedule your appointment, you should call Clerical staff in the Dixon office at **815-285-5638**.
- o If you need to contact your therapist between sessions, you should call the clinic as you usually would. **If your symptoms need more immediate attention, please express to the clerical staff that you have urgent needs, and he/she will communicate this to your therapist.** If your therapist is not available, staff will give guidance about other options to meet your needs. Otherwise, you should expect a return call within 2 business days.
Please call again if you have not heard back from us.
- o The use of email is restricted to the sending and receiving of meeting invites, unless you and your therapist have agreed otherwise.
- o Please do not send emergent or time-sensitive information to your therapist's email account, as it may not be checked regularly. Therapy should not be conducted via email, and content that is usually discussed in therapy sessions, should be restricted to teletherapy sessions.
- o If you are experiencing a mental health or medical emergency, you should call 911 or go to the nearest emergency department immediately.

In order to be able to meet your needs in the event of a mental health or medical emergency, your therapist needs some information from you. Please provide the following:

Name: _____

Address of location where teletherapy meeting will occur:

Phone number: _____

Email address where invite can be sent: _____

Name and contact information of supportive person to be called in an emergency:

Name and contact info of PCP:

Other information that may be important: (i.e. medications, medical conditions, etc.)

X _____

Type/sign name to indicate consent to teletherapy agreement.