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Durham, NH 03824

Informed Consent for Psychotherapy

Welcome. This document describes how therapy at this practice works — what you can expect from me, what I ask of you, and the policies we both agree to. Please read it, ask me anything that is unclear, and sign at the end.

1. WHAT THERAPY IS

Psychotherapy is a collaborative process. It can bring real benefits — relief from distress, better relationships, new understanding of yourself — and it also carries risks: sessions can stir up uncomfortable feelings, and change in one area of life can create strain in another. Progress depends on many factors, and I cannot guarantee a particular outcome. I will discuss my approach with you, and you may ask at any time how our work is going and why I am suggesting what I suggest.

2. CONFIDENTIALITY AND ITS LIMITS

What you share in therapy is confidential. I will not release information about you without your written authorization, except in situations where the law requires or permits disclosure, which generally include:

a. If I believe you are at serious risk of harming yourself or someone else;
b. If I have reason to suspect abuse or neglect of a child, elder, or dependent adult, which I am required to report;
c. If a court orders the release of your records;
d. As needed for billing, insurance claims, or payment processing, limited to the minimum information necessary;
e. In professional consultation or supervision, where I do not reveal your identity.

The exact scope of these exceptions is set by law in the state where I practice, and I am glad to discuss them with you.

3. COMMUNICATION BETWEEN SESSIONS

The best way to reach me between sessions is through my email address, drmichaelkandle@gmail.com that I check frequently Monday through Friday. Phone messages can be left at 603-868-5700 however they are not responded to as frequently as they are less efficient in terms of time and clarity.

4. FEES AND PAYMENT

My fee is $190 per 50-minute session. Copayments will be due at the time of service. Other services — report writing, letters, coordination with other providers, requested records preparation, or services for legal purposes will vary and be discussed prior to those services being provided.

5. CANCELLATIONS AND MISSED SESSIONS

Appointments that are missed or cancelled with less than 24 hours notice result in a loss of income to me and a lost opportunity for other clients waiting for appointments. My fee under these circumstances is $100 (this represents a loss for me as well). If a cancellation is made within less than 24 hours I will make an effort to fill your appointment time with someone on my cancellation list and, if able to do so, will waive the fee. __ (please initial here)

6. EMERGENCIES

I do not provide 24-hour crisis coverage. If you are in immediate danger, call or text 988 (Suicide and Crisis Lifeline, US), call 911, or go to the nearest emergency room. Then let me know what happened, as soon as it is safe to do so, so we can follow up together.

7. YOUR RECORDS

I keep a clinical record of our work. You have the right to see your record and/or receive a copy. By law your records are retained or disposed of after 7 years.

10. QUESTIONS, CONCERNS, or CONFLICTS

Always ask questions whenever confused and share any concerns you have to give me a chance to allay them. If there are any conflicts that we cannot resolve on our own the law provides you the opportunity to contact the NH Office of Professional Licensure and Certification through any of the following means:

Telephone: (603) 271-2152

Email: Complaints@oplc.nh.gov

Website: www.oplc.nh.gov

CONSENT

I have read this document, had the chance to ask questions, and agree to enter psychotherapy under these terms.

Client electronic signature (type full legal name): Date:

Client name (printed):

☐ By checking this box, I agree that typing my name above constitutes my electronic signature and confirms my consent to psychotherapy.

If treating a child or children in your family, please provide the name(s) and sign your consent.

Minor child(ren) name(s):

Parent/guardian electronic signature: Date:

☐ Parent/guardian (if applicable): I agree that my typed name above constitutes my electronic signature and confirms my consent to treatment of the minor(s).

AFTER COMPLETING THIS FORM

1. Click the Download icon (down arrow) at the top of the PDF.
2. Select "With your changes" (if prompted).
3. Save the completed PDF to your Desktop as Kandle Consent.
4. Attach the saved PDF to an email and send it to drmichaelkandle@gmail.com.