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Client Consent Form

Welcome to this private practice. This document contains important information about professional services and business policies. When signed, this document represents an agreement between client and therapist.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need to meet your treatment goals. I will usually schedule one 45-minute session per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless more than 48 hours' notice has been given. If it is possible, we will try to find another time to reschedule the appointment within the same week.

CONFIDENTIALITY STATEMENT & AGREEMENT FOR TREATMENT

You understand that the services provided to you by the therapist are confidential. There are some circumstances under which the therapist is required or permitted by law to release information. These circumstances include instances of suspected abuse or neglect, in situations in which there might be a danger of harm to self or others, or in response to court orders or subpoenas. In all other circumstances, the therapist will carefully maintain your privacy. If the client is a minor, it is most therapeutic if the child's inter-session confidentiality is respected. When working with families in coparenting work, **I do not testify in court proceedings for either party nor are my records available for subpoena**. **Your signature below indicates your adherence to these guidelines.**

CONTACTING ME

I am often not immediately available by telephone. You may leave a message on my confidential voicemail and I will make every effort to return your call on the same day you make it, with the exception of weekends, holidays, and when I am on vacation. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

TREATMENT TERMINATION

If at any time during your treatment, I determine that I cannot continue, I will terminate treatment and explain why this is necessary. Ideally, therapy ends when treatment goals have been achieved. You have the right to stop treatment at any time and I ask that 30-days' notice be given. If you make this choice, referrals to other therapists will be provided. If you are meeting with another therapist, you must first terminate treatment with that therapist before I can begin providing services. If you remain in therapy with someone else and this becomes apparent after we begin, I am ethically required to terminate your treatment. Other legal or ethical circumstances may arise and compel me to terminate treatment. In these cases, appropriate referral(s) will be offered. Also, I do not diagnose, treat, or advise on problems outside the recognized boundaries of my competencies.

PROFESSIONAL FEES

The session fee is **$185.00/45-min and $225.00/60-min or multi-person** sessions. In addition to weekly appointments, I charge this amount for other professional services which may include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other related service you may request of me. This includes legal consultations.

BILLING AND FEE AGREEMENT

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. **If you use insurance to pay all or a portion of the charges, you hereby authorize the release of information necessary to process insurance claims filed on your behalf.** You acknowledge that you are financially and legally responsible for the full payment of charges of services received in the event your health insurance policy does not cover your claim. Payment is accepted in cash, check or credit card. Upon request, you will be provided with an invoice marked paid for services and may choose to submit this invoice to your insurance company for out-of-network reimbursement. A service fee charged by the credit card company will be assessed and charged to your account for credit card payments. A credit card is kept on file in case of late payments or cancelled sessions without 48 hours' notice. You agree that your credit card on file will be charged for any charges or balances due.

Party Responsible for Payment:_____

Name on Card:_____ Type of Card:_____

Card Number:_____ Expiration Date: _____

Security Code:_____Zip Code: _____

Your signature below indicates you have read the information above and agree to abide by its terms during our professional relationship.

Client Name (s)_____

Client/Guardian Signature _____ **Date** _____

Client/Guardian Signature _____ **Date** _____