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INFORMED CONSENT

The purpose of this consent form is to ensure that as my client you understand the following description of psychotherapy, the policies of this office, and the nature of the services provided.

Professional Services

As a client of this office, you are entitled to be treated in a professional and respectful manner. Although in psychotherapy there are no guarantees for success, you are entitled to prompt attention to your needs and competent services provided by a duly accredited mental health professional.

Risks in Treatment

Although psychotherapy is designed to improve the overall quality of life, the process at times involves the discussion of emotional issues that may be distressing. The greatest risk involved in this kind of treatment is often that the treatment provided may not be as effective as you hoped. If this should occur, you are encouraged to discuss this with me so that we can work together to come to a mutually agreeable solution. Success in obtaining treatment goals will also depend upon the client's motivation during the course of treatment.

Treatment Goals

In mental health there are often several ways to approach the problems that patients present with. You have the right to discuss my diagnostic impressions, the recommended course of treatment, goals, and the methods I recommend for obtaining peace treatment goals.

Confidentiality

Information shared with any psychotherapist is confidential and will not be shared with anyone else except for these instances below, which must, by law, be reported to the appropriate authority or significant person:

-You sign a release permitting disclosure of information.
-You are threatening to seriously harm yourself for another person.
-I suspect that a child is being abused.
-Under some circumstance when ordered by the court to disclose information.
-When your insurance company requests information that will be utilized to review the necessity and appropriateness of the care you receive (no information is divulged without your prior knowledge and consent).
-When your account is delinquent and I authorize your name to be released to a collection agency.

Appointments and Cancellations

Clients are seen by appointment only, and an appointment time is reserved specifically for you. Appointments not canceled within 24 hours in advance of the appointment, will be charged at the full rate with no exceptions. Excessive missed/cancel appointments will not be subject to the 24 hour courtesy cancellation policy.

Sessions and Fees

If you decide to attend psychotherapy sessions on a weekly basis, I will reserve a regular time for you whenever possible. A typical therapy session is 50 minutes in length. The fee for a typical 50 minute psychotherapy session is __$100/phone or $150/office___

It is the policy of this office to pay for services when services are rendered, unless other arrangements have been made. All professional services are ultimately the responsibility of the minor's parents or guardians, regardless of insurance coverage. The office will provide you with a complete statement at the end of each month reflecting all sessions, fees, diagnostic codes, and treatment codes. You may then submit the statement to your insurance company for "out-of-network" reimbursement. When you use your medical insurance to pay for psychotherapy you waive some of your rights to confidentiality. Insurance companies require that I assign a psychiatric diagnosis, which will be discussed with you and will appear on your monthly statement. Insurance companies often request access to patient files an attempt to influence the methods or course of treatment so as to save money. Once information is provided to an insurance company, there is no way to ensure that confidential information will be treated

as private. For example, employers are sometimes able to obtain personal information from insurance records. Finally, a psychiatric diagnosis may affect your ability to obtain future health or life insurance at a reasonable cost. I will be happy to discuss these issues with you so that you can make the most informed and appropriate decision for your individual situation.

In addition to session fees, the following services shall be billed at a full hourly rate:

- telephone calls with clients or others involved with clients, lasting longer than 10 minutes.
- Written reports, letters, insurance treatment plans, etc.
- Review of medical records, school reports, testing results and other professional materials.
- School visits and/or meetings at school, including travel time.

If you should need me to appear in court for any reason my daily rate is $1000.00. An hourly rate is also available.

Termination

You have the right to terminate therapy at your discretion. I may also decide to terminate therapy. Reasons for termination include, but are not limited to, the failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client needs which are outside of my scope of confidence for practice (appropriate referrals would be recommended), lack of adequate progress and therapy, or untimely payment of fees. If any decision to terminate is brought up by either of us, I will generally recommend that you participate in at least one, or possibly more, termination sessions. These sessions are intended to facilitate a positive termination experience and give both of us and opportunity to reflect on the work that has been done. I will also attempt to ensure a smooth transition to another therapist by offering referrals to you.

Your signature on the following page confirms that you have read and understood the above information, and that you agree to all limitations and costs. It will be kept on file in the office, and you may keep a copy of this consent form for your personal records. Thank you.

Name **Date**