



NOTICE OF CONFIDENTIALITY AND CONSENT TO TREATMENT

CONFIDENTIALITY:

Relationships with a professional therapist are protected by law. Your (or your child's) identity, the fact that you are being seen in psychotherapy, and the content of our communications are kept completely confidential, except:

- **When you give written permission** to give information to an insurance company, to another professional or to another third party.
- When you give written permission or there is a **court order for records** that are subpoenaed for legal reasons.
- When it is **required by law**: child abuse or neglect, dependent adult or elder abuse or neglect, imminent danger to self or others.
- In addition, your **health plan may require that I disclose certain information to them or their managed care review organization**, in order for them to pay for services rendered to you or your child. Your confidentiality is of great importance, and only information that is essential for authorization of services is released from my office to your health plan or the review organization. **Your signature below will serve as your consent to this limited release of information to your health plan or their managed care reviewer.**

CONSENT TO TREATMENT:

As a psychologist, I offer assessment, psychotherapy, consultation, and referral services. Partial payment for services may be provided through your health insurance plan. However, you are responsible for payment (or copayment, if appropriate). All charges are payable at the time that services are provided, unless there has been another agreement. It may be necessary for you to obtain reimbursement directly from your insurance company. In this case or any other time requested, I will provide you with a bill as proof of payment. At times, referrals may be made to other professionals or agencies, in order to assist you or your child. These services may or may not be covered by your insurance plan. It is your responsibility to determine whether or not such services are covered under your plan, and to pay any charges not covered. Any fees that have remained unpaid after a reasonable effort by the therapist to obtain payment will be sought through the use of a collection agency. You will be warned of such action at least 30 days prior to contacting the collection agency.

Initial evaluation sessions are typically 60 to 90 minutes. My usual fee for these sessions is \$200.

Psychotherapy sessions are typically 50 minutes in length, and the usual fee for these sessions is \$150. All fees are payable at the time of service. **YOU WILL BE CHARGED THE FULL FEE (NOT JUST COPAYMENT) FOR ANY MISSED SESSIONS OR FOR SESSIONS CANCELLED WITH LESS THAN 24 HOURS NOTICE.**

Most people who participate in psychotherapy benefit from it. Like most kinds of health care, this kind of treatment requires a very active effort on your part. In addition, there may be certain kinds of risks involved. For example, the therapy process can be challenging and may at times involve experiencing uncomfortable feelings, engaging in difficult discussions, or facing difficult aspects of your life. Nevertheless, most people find that the benefits outweigh the risks. In fact, sometimes there can be more risks associated with not participating in therapy.

It is important that you participate in this treatment willingly. If you have any questions or concerns about anything contained in this form, about the services being provided to you (or your child), or about treatment options, please voice your questions or concerns in therapy.

I Have Read This Statement, Understand Its Contents, Agree To Its Conditions, And Consent To Treatment.

Signature of Client(s) or Legal Guardian

Date

Name of Client(s) – Please Print

Signature of Therapist