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CONSENT FOR TREATMENT
and LIMITS OF LIABILITY

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship (SKIP THIS SECTION IF MINOR IS NOT BEING SEEN)
Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor client with the parent or caretaker. Clients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist.

In most situations, minors under the age of 18, need a parent or guardian's written permission to receive treatment. Clients who are minors that are not emancipated, should be aware that the law might allow parents or legal guardians access to their child's records. However, since privacy in therapy is crucial, it is our preference that parents/guardians join the therapist in protecting a minor's confidentiality, which includes voluntarily limiting their own access to the minor's records and being satisfied with general periodic reports. Any further communication to parents or others will require the child's authorization except for exceptions to confidentiality as required by law. If the minor or the minor's parent(s) are concerned about this, please discuss it with your therapist.

Parents/Legal Guardians: Please initial and sign below indicating your agreement to respect your child's privacy:

_____ I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

_____ I understand that it is the preference of the clinician NOT to participate, attend or provide documentation in legal court proceedings in order for the therapist to maintain a healthy therapeutic relationship with my child.

_____ I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

I understand that typing my name constitutes a legal signature.

Insurance Providers

My office does not bill insurance providers directly; and I am an out-of-network provider. I can provide, upon request, a monthly receipt which can be used by you for reimbursement directly with your insurance carrier. This monthly receipt may include private information, such as your diagnosis, types of service, dates/times of service, treatment plan, progress, etc. I recommend you contact your insurance provider before beginning this process to fully understand the limits of your treatment and confidentiality. By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Financial Agreement & Cancellation Policy

Fee for service is **$160 per each 50-minute session** and **$200 per each 80-minute session**, and I agree to this fee and assume the responsibility for payment. I understand that payment is expected at the time of each session and that I need to give 24-hour notice for any cancellations, or I will be charged for that scheduled appointment. Your assistance in keeping the office schedule running timely and efficiently is most appreciated.

Termination of Services

Services will be considered terminated if you choose not to reschedule after 30 days, unless specific agreements have been made.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

I understand that typing my name constitutes a legal signature.