Contract for Services and Consent to Treatment

Arrangements/Cancellations (*Therapist may cancel within 24 hrs for Critical Incident Responding)

Neither the therapist nor I/we will cancel an appointment with less than 48 hours notice, except in a rare emergency. Upon signing this agreement: ***in the event that I/we Cancel/No Show, I/we will pay the full fee if the cancellation occurs with less than 24 hours notice;*** If the therapist cancels ***in less than 24 hours***, I/we will have a session without charge*. Emergency cancellations will be considered per incident.

The usual method of communication between sessions will be by telephone. Changes to the agreed upon schedule will be made either in person or via telephone, with the initial message returned for confirmation. I/we will bring other persons to sessions only by prior agreement with the therapist. I/we agree to be present for the full length of therapy sessions (50 minutes, unless modified previously by both the therapist and me/us). ***Calls for purposes other than information or scheduling will be charged in quarter-hour increments of the full fee (e.g., 15 minutes = 25% of full fee).*** If I/we decide to terminate therapy, a discussion will first be held with the therapist during a scheduled session.

Fees (*EAP services: there will be no fee per___ # of covered sessions as reimbursed by your EAP provider.) You will be responsible for fees not covered by your EAP/Insurance provider. Co-pays are due upon services rendered.*

The fee for services will be $ _____ per 50 minute session/60 minute group session, ***payable after the first session and prior to each additional session thereafter. I/we are responsible for directly paying the therapist. Therapist will accept checks/ money orders or cash payment in exact increments.*** Payment for returned checks and penalty fees are due upon notification. The therapist has the right, after fees are three months overdue and I/we have been notified of same, to engage the services of a collection agency. If payment becomes a problem for me/us, I/we will discuss this directly with the therapist. If the therapist's fees change during the course of treatment, I/we will have three months' notice of same.

Confidentiality

In all but a few rare situations, your confidentiality is protected by state law and by the rules of the mental health profession. However, we are required to disclose confidential information if any of the following conditions exits:

(Initial 1-4)

_____ 1. If an individual intends to take harmful acts or dangerous action against another human being, or against themselves, it is the practitioner's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior, or warn the family of the client who intends to harm him/herself of such an intention to act.

_____ 2. A report will be made and information disclosed if the practitioner suspects that a child has been or is at risk for abuse or neglect.

_____ 3. If you are a person over the age of 65 and your practitioner suspects you are the victim of physical or emotional abuse information may be disclosed and the incident will be reported.

_____ 4. If you waive your rights to privilege and/or give consent to limited disclosure by your therapist by agreeing to release information.

I/we understand that therapy services are confidential, under the terms indicated above and in the ***Notice of Privacy Practices***. Some of the major conditions under which the therapist is obligated NOT to maintain confidentiality are: danger to self or others and abuse of children or dependent adults. I/we understand that therapy services are confidential, with the exception of the terms indicated above. I/we also understand that in couple, parent-child, or family therapy, secrets about important information may interfere with therapy, and the therapist may encourage me/us to share critical information with those who should know. I/we also understand that in certain instances, it may be difficult to continue therapy if I/we choose not to reveal important information. ***Therapist will reschedule sessions cancelled due to Critical Incident Responding**, sessions rescheduled will be charged usual fees.

Consent to Treatment

I am/we are entering into this therapy contract with full understanding, participation, and consent. I/we have read the ***Notice of Privacy Practices*** provided by the therapist. I/we understand I/we have a right to a second opinion from another mental health professional at any time and the right to register a legitimate concern with an appropriate agency as indicated in the ***Notice of Privacy Practices***.

Client or Parent/Legal Guardian: _____ Date: ____/____/____

Client: _____ Date: ____/____/____

Therapist: _____ Date: ____/____/____