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Form to *be completed by client (Or parent/guardian if client under the age of* 18*).*

Your name (first, last) _____

(Please initial each item.)

_____CONFIDENTIALITY: All information between psychotherapist and client is held strictly confidential unless:

1. You authorize release of information with your signature (or parent/guardian)
2. You present a danger to self. In this case I may need to call your emergence contact person and/or seek emergency care and/or legal assistance.
3. You present a physical danger to others (or their property). In this case I have a legal obligation to warn the suspected victim.
4. Child or elder abuse is suspected. In this case I have a legal obligation to report suspected abuse to the appropriate authorities. In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken. .

_____FINANCIAL TERMS: You are expected to pay for services at the time of your session, unless we have agreed on other arrangements. We will determine a fee at the outset of our work together. It is your responsibility to notify me if your financial situation changes. Typically, fees will be raised once yearly. In general, it is important to discuss with me any issues that arise connected to our financial arrangements so that these do not hinder our working relationship. Generally payment is made by cash or check, or Zelle (payment app).

(For health insurance terms see below under “health insurance”)

_____CANCELLATIONS/MISSED APPOINTMENTS: Your fee reserves the time set aside for your session(s) each week. If you need to reschedule or cancel a session, please allow for as much advance notice as possible. This office has a 24 hour-one day cancellation policy. You will be responsible for the payment of your regular fee for any sessions cancelled within 24 hours of your scheduled appointment time (if you are using insurance, your insurance company will not cover this cost and you will be responsible for the full fee of the missed session). If you are too ill to come to session, it is better to stay home. When it is possible, sessions may be rescheduled for another hour within the same week and you will not be charged for the missed day. Frequent cancellations may result in a forfeiture of your time or termination of the therapy. You will not be charged for sessions missed due to therapist cancellation, scheduled holidays and breaks.

_____EMERGENCIES: If you are in imminent danger call 911, or your nearest police department or go to the nearest emergency room. I will normally respond to urgent calls within the next business day. If you have health insurance, your insurance plan may also have a 24 hour

emergency service, which you are encouraged to make use of, if necessary. See your insurance card for the correct emergency telephone numbers.

_____ HEALTH INSURANCE:
If you would like to use your health insurance, you are encouraged to bill your insurance company directly for reimbursement of psychotherapy fees. I am glad to provide any information that will assist you. You may request an invoice for me with all of the necessary information required by your insurance company, as needed. Normally I will need up to two weeks to generate an invoice.

_____ RELEASE OF INFORMATION TO THE PRIMARY CARE PHYSICIAN: "I authorize the release of information to my Primary Care Physician for purposes related to my health care."

(name) (date last seen)

(phone)
(fax #)

_____Telephone/VIDEO CALL availability: I will return calls as soon as possible should you need to speak to me between sessions. I do not charge for telephone consultations less than 10 minutes. Consultations of greater length will be pro-rated based on your hourly fee. Sessions may be offered at a distance using telephone or a video platform should you need a session when you are traveling and will be based on your hourly fee.

_____EMAIL CORRESPONDENCE: Email correspondence may be used as a back up to telephone communication, to send documentation, or for scheduling purposes. Leaving an additional phone message especially regarding rescheduling issues or issues of any urgency is preferable. Initialing here you are agreeing that if you choose to use email correspondence, you are aware of the risks to confidentiality (by hacking, third party web platform) in using any form of electronic communication.

_____Client Rights: In addition to confidentiality, as outlined above, you have the right to end your therapy at any time, for whatever reason, without any moral, legal, or financial obligation, except for fees already incurred. You have the right to question any aspect of your treatment with me, and to expect that I will work with you to meet your needs for complementary or alternative treatment. You also have the right to expect that I will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you, all of which would greatly compromise our work together. If it is unavoidable that our community lives intersect (e.g. through attendance at an event, a shared professional membership, chance sightings, etc.), you have the right to not be approached by me and to expect that I will maintain confidentiality outside of the office setting.

_____TREATMENT PHILOSOPHY: During the initial evaluation period, we will clarify together the nature of the concerns for which you are seeking treatment, then define some reasonable treatment expectations, and the best way of making the most of your psychotherapy. The more you put into your psychotherapy treatment, during and between sessions, the more you

will get out of it. You are encouraged to take excellent care of yourself between sessions, and to engage in complementary supportive activities such as support groups, exercise, meditation, spiritual practice, medical care, good nutrition, reading selected materials, completing specific written or other verbal assignments. If you are habitually using substances or alcohol in a way other than prescribed by your physician, it is very important to talk about this with me. *If you show up to a session high on any mood altering substances, you may be asked to return when you are sober.* If this is a repeated problem, it may be grounds for termination.

_____APPEALS AND GRIEVANCES: You have the right to offer me feedback about my work at any time. If for any reason you feel that I can work with you in a way that would be feel more reasonable or effective, please do not hesitate to let me know.

_____CONSENT FOR TREATMENT: "*I understand that while the course of my treatment is designed to be helpful, it may at times be difficult and uncomfortable. I also understand that psychotherapy involves a partnership between therapist and client."*

As your therapist I will contribute knowledge, skills, and a willingness to do my best. The determination of success, however, will ultimately depend upon your commitment to you own personal growth and self care.

I understand and agree to the above:

Client/Guardian's Signature _____ Date

Provider's Signature _____ Date