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CLIENT CONSENT TO TREATMENT

Welcome to my practice. This document contains important information about services and procedures provided to you as a client. Please read the following and discuss any questions you have with me. Your signature is required at the end to confirm your understanding and acknowledge your consent to receive psychotherapy treatment.

CONSENT TO TREATMENT

I understand that the services I and/or my dependent(s) will receive are based on currently accepted practices in the field of mental health. Psychotherapy has both benefits and risks. While it is empirically demonstrated to have beneficial effects on emotions, behaviors and relationships at times it can also arouse distressing thoughts, feelings and behaviors. There are no guarantees as to the results of treatment or of any procedures. It is important to let me know of any concerns you have about your response to our sessions.

CONFIDENTIALITY

Under most circumstances, all communication between you and I is confidential, unless permission is given by you, in writing, to convey information to a third party. There are certain exceptions to these circumstances under which I may be legally required to disclose this information. These include:

- If I have reasonable cause to suspect you of child abuse, dependent- adult or elder abuse.
- If you communicate a threat of violence towards an identifiable victim and in my judgment you have the intent and ability to carry out that threat.
- If, due to your words or actions, I consider you likely to harm yourself unless protective measures are taken.

Disclosure may also be required in certain legal proceedings. If you have any concerns about any legal proceedings you are involved in or expect to be involved in, please let me know.

PROFESSIONAL CONSULTATION

It is commonly accepted practice in psychotherapy to seek consultation on cases when I believe it may benefit treatment. Should I consult with other mental health professionals for the purpose of treatment, I will refrain from revealing your identity or related identifying information. Please come to me with any questions you may have.

ACCESSIBILITY

I carry a cell phone with the number listed above, and while I am not always able to answer my phone, if a message is left I will reply by the next business day. Telephone calls lasting longer than ten minutes will be billed at the agreed-upon hourly rate. Please keep in mind that as a private practitioner, I am not equipped to respond to emergency needs or handle crisis intervention phone calls. Emergencies should be handled by either going to your nearest hospital emergency room, calling a crisis hotline (**University of Michigan Psychiatric Hotline - 734-996-4747; National Suicide Hotline -1-800-273-TALK**), or by calling **911** for crisis response.

APPOINTMENTS
Sessions are 50 minutes in length and begin at the scheduled time. If you arrive late, your session will be shorter. If I arrive late, your session will be extended to make up the time. If you must cancel a session, please let me know 24 hours in advance. **You will be responsible for the full fee of any session canceled with less than 24 hours notice and for any missed appointments. Insurance will not cover missed appointments.**

TERMINATION OF THERAPY
Our therapeutic relationship must end at some point in time. Ideally we will openly discuss and plan for termination prior to the end of our relationship. However, you do have the right to terminate the therapeutic relationship at any time.

FEES, BILLING, PAYMENTS
- All services are billed at the rate agreed upon prior to service.
- Payment is accepted at the beginning of each session.
- You are personally responsible for payment at the time of service via cash or check.
- Statements will be provided for you to submit to your insurance provider for reimbursement upon your request.
- If I am a provider for your insurance, I will accept their assigned fee once coverage begins and bill your insurance electronically.
- There will be a $30 returned check fee charge

EMERGENCY CONTACT
In case of emergency, therapist has permission to contact the following person:

Name:_____

Relationship:_____ Phone:_____

By signing below I acknowledge I have read, understand and agree to the information stated in this Consent for Treatment. It also serves as acknowledgement that you have received a copy of the HIPAA Notice.

_____ _____
Signature **Date**

_____
Printed Name

_____ _____
Signature of Witness **Date**