**TO MY CLIENTS:**

# Informed Consent for Treatment

Welcome. I look forward to working with you. I will make a reasonable effort to accommodate your needs. So that you may be fully informed about the services you are receiving, please take the time to read the following information about my practice policies. **Please do not hesitate to ask any questions if any of the following seems unclear. If you have any questions, please ask me.**

I would like you to be aware of your right to confidentiality and my commitment to safeguard that right. The patient-therapist relationship is a confidential and privileged one, and is thus protected by law and ethical code. However, there may be limits to confidentiality depending on your particular circumstance. For example, if your health care carrier is under the Federal ERISA act, it is entitled to and may request information about your sessions. Likewise, PIP, Workers’ Compensation, and other legal/court cases may override confidentiality. In cases in which there is a clear risk of harm to self or others or of suspected child abuse, confidentiality is limited by law.

If you are involved in a legal case in which your mental status is at issue and the services you have requested are NOT for expert opinion or testimony, then please be advised that as your therapist, in order to avoid a conflict of interest and to preserve the therapist-patient relationship, I can not serve as in independent expert at a later date. If you are in need of an expert opinion or evaluation, please make that known to me BEFORE the start of services. If you have any questions regarding these circumstances, you are encouraged to discuss this with me.

If you participate in group, family, or couples therapy, I insist that you do not discuss the contents of those sessions with any person other than those in the same counseling sessions. Also, you must agree not to hold me responsible for any group/family/couples therapy member’s behavior. In the case of minors, it is important that parents/guardians understand the need of their children to develop trust in their therapist. Thus I ask that parents/guardians limit their desire for specific details of the treatment. However, I will be sure to address any concerns parents may have regarding their child’s treatment.

If you have been referred for psychological or neuropsychological testing, I will assess the extent and type of testing that will be most useful in answering the diagnostic question. This may be done before or at the time of the first appointment, or as testing unfolds, depending on the nature of the case.

If you choose to engage in psychotherapy, please be aware that the process of psychotherapy involves change and can be an exciting process. At times, it may also seem frustrating and may arouse strong, difficult emotions. You may discover that the way you think about the world, the way you view your past, present, and future, and the way you relate to others may be altered. Therapy will require your work and commitment. My most important mission as a therapist is to help you make progress in your work toward reaching your goals. I will strive at all times to utilize my best clinical skills and professional judgment in this endeavor.

Individual and family therapy sessions are usually scheduled to last 45 minutes, unless otherwise indicated. I will make an effort to begin your session in a timely fashion and would likewise appreciate your timeliness in keeping appointments. The frequency of therapy sessions is arranged by you and me, based on recommendations and your needs. You are free to terminate therapy at any time. Termination is usually a mutual goal that is planned for by the patient and the therapist. If at any time you feel that therapy is not meeting your needs, you are strongly encouraged to present your concerns to me.

Regarding billing, payment in full is due at the time the service is rendered unless other arrangements have been made. Information regarding fees is available upon request and is usually posted in the office. I reserve the right to charge an interest charge of 1 ½% per month (18% per annual percentage rate) on accounts that are greater than 30 days overdue. There is also a returned check fee. Please note that in cases in which the account has been neglected by the patient and there has been no show of good faith despite our repeated attempts toward resolution, I reserve the right to turn the account over to a collection agency. In hardship circumstances, I ams available to discuss payment arrangements.

There may be times when you may receive a mailing from my office, such as an appointment confirmation, notice, bill, report, or other communication. My mailing envelopes display my name and address. If this is of concern to you, please inform me in writing immediately and I will try to make other arrangements for mailing.

I am available by telephone at times other than your scheduled appointment, if there is a matter that cannot wait until the next session. For any telephone calls which last fifteen minutes or longer, I reserve the right to charge you a fee proportionate to the individual psychotherapy rate. If you have an emergency, and you call after regular business hours or cannot reach me, please call me at 973-271-1363 or go to your local hospital emergency room immediately.

I reserve the right to charge you for any missed appointments, or appointments that are canceled with less than 24 hours notice. In the case of a bona fide emergency, the charge will be waived.

I am not responsible for your insurance or health care coverage. I strongly encourage you to clarify the extent of any coverage with your carrier. Please be advised that what your insurance provider/representative says over the phone to either you or me may not always be correct or clear. I will try and assist you with the information you may need to submit bills to your carrier. Ultimately, you are responsible for payment of the services rendered to you.

**After you have read this form, please sign your name and the date below indicating that you have understood and accepted what you have read. Thank you.**

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Signature of Patient if age 14 or over PRINT PATIENT NAME ABOVE

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Signature of Parent or Sole Legal Guardian if Patient is under 18 years of age Date

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Signature of Other Parent if joint custody of Minor Date