Jennifer Theriault, MSW, LCSW

INFORMED CONSENT FOR PSYCHOTHERAPY

Welcome to my practice and thank you for choosing me as your psychotherapist. This document contains important information about the process of psychotherapy, confidentiality, and my office policies. When you sign this agreement it will represent an agreement between us.

Contact Information

Patients and families needing to contact me should use the following:

C) (917)532-1944

Routine Calls

Messages left on my voicemail will be returned by the next business day. If for any reason you have not received a return call by the next business day please call again.

Emergencies

In the event of an emergency involving a patient's safety (i.e. suicidal or homicidal thoughts or attempts) patients and families should do whatever is necessary to assure the safety of the patient first. This may include calling 911 or proceeding to the nearest emergency room. After assuring the patient's safety, please call me.

Fees

Initial consultations are 60 minutes at $350. Individual, couples, and family sessions are 45 minutes at $300. Fees for service are due either at the time of service, or can be paid monthly, and are payable by cash, check, or credit card. Patients will receive a billing invoice/statement on the last day of the month. If you have an out of network benefit and wish

to submit this to your insurance company for reimbursement, please let me know and your statement will include the necessary codes and diagnosis required by most insurance companies. I do not participate with any insurance companies or submit claims directly to them, but please feel free to let me know if you have questions or problems. Whenever possible, I will be happy to assist you.

In the event of a returned check, the patient (or his or her legal guardian) is responsible for the original amount as well as any resulting bank fees.

We have made and agreed upon a rate of $_____ per session

Initials _____

Phone/Skype Sessions

Many patients find it comforting to know that they can schedule a telephone or online session if they are unable to come in for their session. There is no charge for a phone call lasting 15 min. or less. Phone sessions lasting longer than 15 min. will be prorated at the regular therapy rate.

Cancellations

In the event that a patient needs to cancel an appointment, notification must be given at least **24 hours prior to the appointment time**. I will make every attempt to reschedule at a time that works well for both parties. If unable to reschedule and adequate notice is not given, the full session fee will be charged.

Initials_____

Confidentiality

Issues discussed in therapy are generally legally protected as both confidential and "privileged". However, there are limits to this privilege. These situations are:

1. Suspected abuse or neglect of a child, elderly person, or a disabled person.

2. When I believe you are in danger of harming yourself or someone else or you are unable to care for yourself.

3. If you report that you intend to physically injure yourself or someone else, the law requires that I inform that person as well as the legal authorities.

4. If I am ordered by a court of law to release information as part of a legal involvement or when otherwise required by law.

When necessary, you may be asked to sign a **Release of Information** so that I may speak with others.

Record Keeping

A clinical chart is maintained describing goals, progress, dates of service, and other information relevant to your treatment. Your records will not be released without written consent, unless outlined in the Confidentiality section above.

Vacation Coverage

In the event that I go on a vacation that would prevent me from regular communication, a covering therapist will be available. The covering therapist will be provided with basic information about you. My voicemail will reflect both my absence, as well as how to contact the covering therapist.

Consent For Treatment

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement. I understand that I may withdraw from treatment at any time. I have also received a copy of the office **Notice of Privacy Practices**, which describes how medical information about me may be used and disclosed and how I can get access to this information.

Name (please print):_____
(relationship to client)_____

Client signature _____ **Date** _____