

Informed Consent and Authorization for Psychotherapy

Payment of Fees

Paying for therapy is often a very sensitive topic, and we can discuss your concerns about payment as needed. However law requires that all fee(s) are established and agreed to before we can begin. This section clarifies all fees, and defines your financial responsibilities.

1. The standard fee is \$150.00 for initial intake evaluation and \$130.00 per (50) minute session, payable each session and beginning at your first appointment. Groups are \$25.00 per meeting based on a six week commitment. A \$15.00 returned-check fee will be assessed.
2. Canceling or rescheduling appointments requires a (24) hour notice by telephone to avoid having to pay the entire fee for a missed session. (No e-mails please.)
3. Written reports of any type are billed to you at \$130.00/hr.
4. Telephone conversations between us, for any reason, in excess of (15) minutes per day may be billed proportional to your hourly fee.
6. Authorized telephone consultation(s) with anyone concerning your therapy will be billed to you at \$125.00/ hr. This service is generally not covered by insurance.
7. Appearing at meeting(s) or legal proceedings on your behalf is not covered by insurance, and is billable to you at \$130.00/hr. for the entire time spent away from the office.

Your initials here agreeing to the ‘Payment of Fees’: _____

CONFIDENTIALITY LIMITS AND EXCEPTIONS

1. Normally, everything we discuss will be held confidential. Unless you provide a signed authorization, I will not speak to or correspond with anyone about you.
2. If you choose to break confidentiality in any way (i.e., sending me an e-mail, applying for insurance reimbursement, telling anyone about your therapy, use an analog cell-phone) I cannot control, or be held liable for the outcome.
3. Law and professional ethics either mandate or permit therapists to break client confidentiality under certain circumstances. Some ‘exceptions to confidentiality’ include situations in which there is reasonable suspicion that any of the following has ever occurred or is occurring now:
 - you or your child present a danger to self or others
 - a child or dependent adult is the victim of emotional, sexual or physical abuse, neglect or unjustified mental suffering
 - a dependent adult or any person over the age of 65 years is the victim of physical abuse, emotional abuse, abandonment, forced isolation, fiduciary abuse, or neglect

Note that the preceding is a sample, and not a complete list of exceptions to confidentiality.

Your initials here agreeing to ‘Confidentiality Limits & Exceptions’: _____

MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL EVALUATIONS

1. If medical, psychiatric and/or psychological evaluation seems warranted, we will discuss the nature of these evaluations and appropriate referrals will be provided. If the need for evaluation(s) by other professionals is established and you do not follow these recommendations, your therapy may necessarily be suspended or terminated.
2. Certain medications that ease emotional suffering may be prescribed before and/or during the course of treatment. If you are already taking prescribed medications when therapy begins or you begin medication during the course of this therapy, your medication compliance will be a condition of treatment.

Your initials here agreeing to ‘Medical, Psychiatric & Psychological’ conditions:

LIMITS OF COMMUNICATION

1. Every effort will be made to assist you, especially during crisis. However, there may be times when contacting you won't be possible. Therefore you must agree to first call 911 or go to the nearest hospital Emergency Room for assistance, any time you suspect you are in crisis.
2. As a standard business practice, each appointment ends (50) minutes from the scheduled start of the appointment, regardless of your arrival time. I am not able to extend sessions since other clients may be waiting.
3. Correspondence sent to this office is retrieved at random, and several days may go by before mail is retrieved. My office hours vary randomly from day to day, and normally no one is available to sign for deliveries.
4. I do not use a pager or rely on a cell-phone for business purposes. Calls are retrieved from my voice mail at (203) 663-0233 several times during the day at random intervals.
5. At times, my other work settings do not permit me to receive or place telephone calls. Your ‘Caller ID’ or ‘Call-Blocking’ may also prevent my return calls from these or any other location.
6. E-mail and fax machines are not confidential methods of communicating and are not used without your signed consent.

7. I maintain very firm personal boundaries. I reserve the right to terminate treatment if, for any reason, a client obtains my home telephone phone number or my residential address.

Your initials here agreeing to ‘Limits of Communications’: _____

TREATMENT TERMINATION

- If at any time during the course of your treatment I determine I cannot continue, I will terminate treatment and explain why this is necessary. Ideally, therapy ends when we agree your treatment goals have been achieved. Additional conditions of termination include:
- You have the right to stop treatment at any time. If you make this choice, referrals to other therapists can be provided and you will be asked to attend a final ‘termination’ session.
- Professional ethics mandate that treatment continues only if it is reasonably clear you are receiving benefit. If you are meeting with another therapist, you must first terminate treatment with that therapist before I can begin providing services. If you remain in therapy with someone else and this becomes apparent after we begin, I am ethically required to terminate your treatment unless of course that therapist is seeing you as an individual concurrent to your treatment with me for coupling sessions, and vice versa.
- Other legal or ethical circumstances may arise and compel me to terminate treatment. In these cases appropriate referral(s) will be offered. Also, I do not diagnose, treat, or advise on problems outside the recognized boundaries of my competencies.
- Other situations that warrant termination include: regularly becoming enraged or threatening during session; bringing a weapon onto the premises; persistent drug abuse; arriving under the influence of drugs or alcohol; disclosing illegal intentions or actions.

Your initials here agreeing with ‘Treatment Termination’ conditions: _____

OFFICE ENVIRONMENT

Please do not use cell-phones, laptops or other electronic devices in the waiting area.

AUTHORIZATION TO COMMENCE PSYCHOTHERAPY

- Your signature below will verify that you have read (or that I have read to you) the information in this authorization and that you asked questions about anything you have not understood up to this point. By signing, you freely acknowledge your willingness to undergo treatment using psychotherapy methods, as I deem appropriate and in accordance with this ‘Informed Consent.’
- You also agree to enter into a professional business arrangement according to all business practices outlined in this agreement. You accept total financial responsibility for payment of all fees and services as described, regardless of insurance coverage or any other ‘third-party’ payers.
- You will also be releasing me of any liability that directly or indirectly results from disclosure or exchange of any information covered in this agreement. At your request, a copy of this and any other document in your record that bears your signature will be provided.

Client Signature

Date

Witness Signature

Date