**Informed Consent & Agreement For Psychotherapy Services**

This document provides important information regarding your treatment. Please read the entire document carefully and ask me any questions that you may have before signing it.

**I am a New York State Licensed Clinical Social Worker (LCSW), license number 077267-1.**

**Fees:** The fee for service is $90 per 50-minute individual therapy session or $120 per 90-minute couples or family session, payable at the time that services are rendered. You will be notified in advance if any fee adjustment occurs. *If there is a need for telephone contact with you or a third party other than for scheduling purposes, you are responsible for payment of the fee (on a pro rata basis) for calls longer than 10 minutes.*

**Scheduling and Cancellation Policies:** If an appointment is missed or canceled with less than 24-hours’ notice, you may be charged the full fee for that missed session. Exceptions may be made for illness or unavoidable emergencies.

**Insurance:** Please inform me if you wish to use health insurance to pay for services. I can assist you in seeking reimbursement but cannot determine whether your insurance will pay for the services provided. You are responsible for verifying and understanding the limits of your insurance coverage and obtaining any prior authorization needed. *Be aware that insurance limits coverage to diagnosable disorders, which become part of your medical record.*

**Contact with Other Professionals:** In order to provide quality services, I may need to speak with other professionals, such as your physician, psychiatrist, or past therapists. You will be asked to complete a release of information authorizing these exchanges.

**Record Keeping:** I am required by law to maintain clinical and business records regarding your treatment. These are kept in a locked location and/or a private, password-protected computer. You may release these records to yourself or another party by written request.

**Confidentiality:** The information you disclose to me is confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. *Exceptions to confidentiality include, but are not limited to, threats of serious harm to yourself or someone else; suspected child, elder, or dependent adult abuse; and court orders to testify or produce records.*

I will not disclose information about marital or family therapy without written authorization from all persons who participated in the treatment. *However, I use a “no secrets” policy when conducting family or marital/couples therapy.* This means that I do not withhold information between parties of shared therapy when the information in question impacts the integrity of the therapy, such as an affair, substance problem, or intent to leave the relationship.

**Therapist Availability:** You may leave a message for me at any time on my confidential voicemail at 585-953-8587. If you would like a return call, please leave your name, phone number(s), and a brief message explaining the nature of your call. Phone calls are generally returned within 24 hours.

**Emergencies: As a solo, outpatient practitioner, I am unable to personally provide continuous 24-hour crisis services.** *In the event of a psychiatric or medical emergency involving a threat to your safety or the safety of others, please call 911, go to the nearest emergency room, or call the Psychiatric Emergency Assessment Team through Lifeline at 585-275-5151.*

**Acknowledgement**

By signing below, you acknowledge that you have reviewed, fully understand and agree to the terms and conditions of this Agreement.

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Signature of Client (or authorized representative) Date

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Signature of Client (or authorized representative) Date