CLIENT-THERAPIST AGREEMENT (Informed Consent)

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CLIENT-THERAPIST AGREEMENT (Informed Consent)

1. **Confidentiality:** All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone by me without your written permission, except where disclosure is required by law.

2. **When Disclosure Is Required By Law:** Some examples of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled.

3. **Emergencies:** If there is an emergency during our work together, or if I become concerned about your personal safety, I may contact the person whose name you have provided on the biographical sheet. This includes the possibility of you injuring someone else. My action of using your emergency contact would be for the sole purpose of ensuring that you receive proper psychiatric care, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. I would abide by the limits of the law for disclosure of information about you in such a situation. When possible, I will make every effort to make you aware of the possibility of such a situation and would inform you if an emergency release if information occurred, even after termination.

4. **Litigation Limitation:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will require me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless otherwise agreed upon.

5. **Emergency Procedures:** In case of an emergency, you can call my cell phone at (301) 807-2347. Please do not use email for emergencies. If you need to talk to someone right away call:

   - Crisis Link (suicide and crisis hotline) for the Washington Metropolitan (free call): (202) 527-4077
   - Access Help Line (24/7 DC Mental Health including mobile psychiatric response units): 1-888-793-4357
   - Montgomery County Mental Health Hotline: 301-738-2255
   - Prince George's County Mental Health Hotline: 301-864-7161
   - Arlington County Mental Health (business hours): 703-288-1550
   - Police: 911

6. **Payments & Insurance Reimbursement:**

   - $180 for a 50-minute session
   - $215 for a 60-minute session
   - $270 for a 75-minute session

   Reports (longer than five minutes), or longer sessions will be charged at the same rate, per-minute, unless indicated and agreed upon otherwise. If requested, I will provide you with a copy of your billing statement which you can then submit to your insurance company for reimbursement, if you so choose.

7. **The Process of Therapy/Evaluation and Scope of Practice:** Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. There is no guarantee that psychotherapy will yield positive or intended results and it is normal to experience some unpleasant feelings from therapy. On the other hand, psychotherapy may help you change your unhealthy or maladaptive thoughts and behaviors and give you more rewarding interpersonal relationships. Our collaboration in addressing your problems will be enhanced by the amount of time and effort you devote to our work *outside* of our therapy sessions as well as during our appointment. During our sessions it is important that you be forthcoming with feedback about how you are feeling about our work so we can decide together if changes in your treatment should be made.

   I do not provide custody evaluation recommendations, medication or prescription recommendations, or legal advice, as these activities do not fall within my scope of practice.

8. **Cancellation:** Re-scheduling or canceling an appointment must be done at least 24 hours in advance of our scheduled session. You will be charged the full fee for cancellations

done less than 24-hours in advance. I will not charge you a fee if you (or your child) are sick, but if cancellations due to sickness become routine, I will discuss this with you and reserve the right to institute a new Cancellation Policy. I will not provide you with a bill for missed sessions.

I HAVE READ AND AGREE TO THE CONTENT IN THE PARAGRAPHS 1 TO 8 IN THE CLIENT-THERAPIST AGREEMENT (INFORMED CONSENT)

Printed Name of Client ______________________ Date ______________

Signature ______________________

Printed Name of Client ______________________ Date ______________

Signature ______________________