POLICIES AND INFORMED CONSENT

GENERAL: We are very pleased to have the opportunity to work with you. This document contains important information about our policies and by signing below, it will represent an agreement between us. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular issues you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, etc. On the other hand, psychotherapy has also been shown to have benefits for people. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience. By the end of the first few sessions, first impressions will be shared and concurrently you should be able to determine if you think this process will work for you. If you have questions about our procedures, we should discuss them whenever they arise.

PAYMENT: Our fees will be discussed privately with you. Payment in full is expected at the time of service, or according to a mutually agreed upon schedule. In addition to weekly appointments, we charge for other professional services you may need, such as report writing, telephone conversations, extended email dialogues, attendance at meetings with other professionals that you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. Your account is expected to be paid in full at the end of each month. Most health insurance policies will cover some portion of mental health treatment. Most of the providers of this practice do not participate as “in-network” providers. We will be happy to help you understand any questions you may have regarding your insurance policy; however, we do not submit bills to insurance companies, and you (not your insurance company) are responsible for full payment of our fees.

CANCELLATION POLICY: Once an appointment is scheduled, we have a **strict 24-hour notice** for cancellation. Except in cases of family/medical emergency and illness, appointments cancelled within 24-hours will be charged full fee for the appointment. These fees are not covered by health insurance and are the client’s personal responsibility.

PRIVACY: Confidentiality is your right and our duty. In general, the privacy of all communications between a client and a psychologist is protected by law, and we can only release information about our work to others with your written permission. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some legal proceedings, a judge may order testimony if he/she determines that the issues demand it, and we must comply with that court order. The privacy of all records pertaining to your treatment will be maintained securely by us. Records will be kept for a minimum of seven (7) years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, per Illinois and Federal law. You have the right to review your records (including the record of disclosures made) upon your written request. We charge a reasonable fee for copying records requested by you. If at any time you feel your privacy has been violated, you have the right to file a grievance with us and/or with the Secretary of the U.S. Department of Health and Human Services. Note, however, that the law requires the release of otherwise confidential information when the provider reasonably believes disclosure is necessary to protect against harm to yourself or others, when there is suspicion of child or elder abuse, and when records are demanded by Court Order.

DISCLOSURE OF MINOR’S TREATMENT INFORMATION TO PARENTS: Therapy is most effective when a trusting relationship exists between the psychologist and the client. Privacy is especially important in earning and keeping that trust. As a result, it is important for minor children to have a “zone of privacy” where they feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. It is our policy to provide you with general information about your child’s treatment, but NOT to share specific information your child has disclosed to us without your child’s agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm.

TREATMENT OF MINOR CHILDREN OF SEPARATED OR DIVORCED PARENTS: If our services are requested for a minor child of divorced or separated parents, we must receive consent in advance for our services from a party legally authorized to give consent for healthcare services. Payments of fees will be the sole responsibility of the parent or guardian signing below as the “responsible person” notwithstanding any court order or decree assigning financial responsibility for healthcare to any other party. Our office cannot bill such third parties.

THANK YOU: If you have any questions, please do not hesitate to ask. Your signature below indicates that you have agreed to all sections of the policies and consent to treatment form. Thank you.

Client: (18 + yrs.)	**Printed Name**	**Signature**	**Date**
Client: (12-17 yrs.)	**Printed Name**	**Signature**	**Date**
Parent: (Child <18)	**Printed Name**	**Signature**	**Date**
Provider:	**Printed Name**	**Signature**	**Date**