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404-872-8065

INFORMED CONSENT

Please read the following information carefully. Feel free to discuss any questions or concerns that may arise.

FEES: The fee for each 50-minute psychotherapy session is $150.00. Exceptions to that rate may be made for students or in the case of extenuating circumstances. Fees are payable at the end of each session. Sessions that are not canceled or rescheduled within 24 hours' notice will be charged at the hourly rate. Any phone calls, which last longer than 10 minutes, will be billed at a pro-rated amount.

CONFIDENTIALITY: Strict confidentiality regarding all treatment records will be maintained except when mandated by law. The American Association for Marriage and Family Therapy's ethical principles require exception to confidentiality only under such extenuating circumstances as when a client expresses a serious intent to inflict life-threatening harm to him/herself or another, or abuse to a minor or an elderly person. There are also other possible limits to my ability to maintain confidentiality. Court orders have been used to gain access to clients' records in some cases.

EMERGENCY PROCEDURES: Should you have an emergency and need to reach me, call my office number. If I am not available, you can leave a message in my voice mail box (ext. # 3) or ask the answering service to try to reach me. I check my messages on a regular basis and will return any emergency calls as quickly as I can. If you call in the evenings or on a weekend, I may not receive your message until the next business day. Should you need emergency assistance before I return your call, there are several options: 1) Call a friend, a family member, or another member of your support network. 2) Call 911 or an emergency crisis hot line number.
3) Go to the nearest hospital emergency room.

I consider myself a symbolic/experiential psychotherapist, which I can explain to you as we develop a therapeutic relationship. While psychotherapy can be an effective mode of treating a variety of life problems, positive results cannot be guaranteed. It is important that we seek to establish an open working relationship in which we can discuss your needs, hopes, and expectations as we develop goals for your therapy.

I, the undersigned, have read and understand the above information and I consent to treatment under these conditions. I understand that I have the right to withdraw my consent at any given time.

NAME OF CLIENT (PLEASE PRINT): _____

SIGNATURE: _____

SIGNATURE OF GUARDIAN IF CLIENT IS A MINOR:_____

DATE: _____