Informed Consent for Psychotherapy

Services: Services may include family, couple, individual and group therapy as well as school consultations. These services may include the participation of parents/guardians and other significant family members, when appropriate. Any recommendations for treatment are first discussed with and approved by you.

Confidentiality: All information concerning your interaction with me is held confidential and is released only through procedures consistent with the law and professional ethics. The limits of confidentiality are such, however, that clients who use their mental or emotional condition as an issue in a court of law may lose their right to confidentiality and the court may successfully order records released and/or require individual psychologists to testify. The law also requires that if there is knowledge that a person may harm him/herself or any other person, that steps be taken to prevent this harm even if the steps taken breach confidentiality. The law also requires that I report any reasonable suspicion of child or elder abuse.

Fees: You are expected to pay at the time of service. Should you become delinquent in payment of fees, and if there is no compelling financial reason, our therapeutic work may be disrupted or terminated. If insurance is to be used for payment, you are responsible for contacting your insurance company and for understanding your insurance benefits.

Appointment cancellation policy: I ask that you give me a minimum of 24 hours notice to cancel (or change) an appointment. Charges apply for appointments canceled with less than 24 hours notice, although extenuating circumstances are considered where appropriate.

Contacting me: The telephone number for my practice is 847-894-8292. You may leave confidential voice mail messages for me at that number at any time. I check messages regularly. For life-threatening emergencies, please call 911 or go to the emergency room of the nearest hospital.

Your Consent to the Terms of this Agreement

I/We the undersigned understand this Service Agreement and seek psychotherapy in accordance with this agreement. A signature is required from the parent(s) or guardian(s) of children in treatment. Each child age 12 or older who is involved in treatment must also sign this agreement.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_