

## Informed Consent

Welcome. The following information is intended to help you feel as comfortable as possible and answer some of the questions you may have as we begin therapy. I encourage you to ask any other questions at any time.

As with any treatment, there are some risks as well as many benefits with therapy. Risks sometimes include experiencing uncomfortable or painful feelings such as sadness, anxiety, anger, frustration, or other feelings. These risks are normal and to be expected when people are making important changes in their life. While you consider these risks, you should also know that therapy has been shown to have many benefits that include significant reduction of distress as well as improved relationships and coping skills, increased self-awareness, and the satisfaction of meeting your personal goals.

**Appointments and Cancellations:** Therapy sessions will typically be on a weekly or bi-weekly basis; duration and frequency vary depending upon the nature of your individual needs. If you need to cancel an appointment, please tell me as soon as possible, but at least twenty-four (24) hours in advance of your reserved appointment time. Please understand that because this time is reserved for you, the lack of adequate notice prevents sufficient time to schedule other clients in need. If you do not provide 24 hours notice of a cancellation, you are responsible for paying the full amount for the session. (If you are using insurance, please note that appointments cancelled with less than at least 24 hours notice, missed or failed appointments are not eligible for insurance benefits and you are responsible for paying the full fee for that session, not just your co-pay amount.) If a last minute problem prevents you from attending an appointment, consider having a telephone appointment at that time.

**Confidentiality:** In all but a few rare situations, your confidentiality is protected by state law and by the rules of my profession. Information you share with me and all matters relating to your therapy will be kept strictly confidential and will not be disclosed without your written permission to release information to a specific individual or organization, such as another healthcare provider. In addition, if I believe that you are in imminent danger of harming yourself or others, or in any situation in which a child or elderly person is put at risk, such as in the case of sexual or physical abuse or neglect, I am required by law to report that danger. In such a situation, I would talk with you about both my concerns and the action taken, if feasible.

**Phone and Emergency Contact:** Don't hesitate to contact me by phone. If I am unavailable when you call, please leave a message on my confidential voicemail. I'm usually able to return calls within the day, but there can be unavoidable delays. I will return your call as soon as possible. If you are experiencing an emergency, please call 911 or go to the nearest hospital emergency room. No fees are charged for phone calls regarding appointments and similar matters; nor are fees charged for phone calls requiring just a few minutes; however, a pro-rated charge will be made for therapy conducted over the phone that require more than 15 minutes. This would be billed at the same rate as private face-to-face therapy.

**Insurance Coverage:** If you maintain health insurance, part of your therapy expenses may be covered. You are responsible to contact your insurance company to determine insurance benefits. Please be aware most insurance agreements require me to provide a clinical diagnosis and sometimes additional clinical information such as a treatment plan or summary or, in rare cases, a copy of the entire record. Remember, if fees you expect your insurance company to cover are rejected for any reason, these fees become your responsibility to pay.

**Fees:** You are expected to pay for services at each session. If you are utilizing insurance benefits, you are expected to pay your deductible, co-pay or coinsurance amount, as estimated by your insurance quote of benefits. Currently, acceptable forms of payment are cash, credit/debit card (VISA, MasterCard or Discover), or check (payable to "Priscilla Brinkman, LCSW"). **Remember, appointments must be cancelled 24 hours prior to appointment time or you will be charged in full.**

**Insufficient funds and delinquent accounts:** A \$25 charge will be assessed for any check given in payment of your account if the check is not honored at the bank because of insufficient funds. The charge will be added to your balance due and shown on your statement. Late payments will be subject to a penalty fee of 12% per annum. Delinquent accounts may be sent to collections if fee payment obligations are not met in a timely manner, an additional 35% will be added to your account if sent to collections.

**Ending Therapy:** You can end therapy at any point you wish. Usually therapy pursues specific goals and you and I will discuss together an appropriate termination process. If you decide you want to terminate your treatment, but have a scheduled appointment, please call me and explain that you wish to take a break or end your therapy. You are always welcome to call or continue your therapeutic work if you find the need to in the future.

**Ethics & Professional Standards:** As a therapist, I work to uphold the most responsible, ethical and professional standards possible, and I am accountable to you. If you have any questions or concerns about your course of contact with me, please feel free to discuss these issues with me. In signing this contract you are agreeing that should you have any dissatisfaction(s) or concern(s) about your treatment, that you will do your best to indicate your concerns to me so I can attempt to address them to your satisfaction. If you are unhappy with your services here and need help finding additional or alternate assistance, I will assist you in locating a more suitable referral or therapy resource.

**Consent for treatment:** I consent to be treated as a client by Priscilla Brinkman, LCSW. My signature below indicates that I have read and understand the information provided in this document and agree to abide by its terms.

\_\_\_\_\_  
Signature of Client (12 years and older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Client (Couples/Family Counseling)

\_\_\_\_\_  
Date

**Consent for treatment of children or adolescents:** I/We consent that \_\_\_\_\_ may be treated as a client by Priscilla Brinkman, LCSW. My signature below indicates that I have read and understand the information provided in this document and agree to abide by its terms.

\_\_\_\_\_  
Signature of Parent/Guardian (for all children up to 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian (for all children up to 18 years of age)

\_\_\_\_\_  
Date