**Informed Consent & Agreement for Services**

This document is intended to provide you important information regarding your treatment. Please read it entirely and carefully and be sure to ask me any questions you may have regarding its contents.

**Information about Your Therapist**

I am a Licensed Clinical Social Worker (LCSW) licensed in both Illinois and North Carolina. I received my BA from Columbia University and my MSW from San Diego State University. I am a Certified Somatic Experiencing Practitioner (SEP), a therapy focused on treating trauma (acute and developmental), healing chronic stress, and guiding the nervous system back to more resiliency. I am also an Advanced Practitioner in Emotionally Focused Therapy (EFT) for Couples. I completed three years of post-graduate training in Bioenergetic Analysis, a form of psychotherapy that combines talk therapy with an understanding of the importance of the body – and the energy that underlies both body and mind – in maintaining psychological and emotional health. Parenting, developmental trauma and boundaries are particular areas of interest. Separately I enjoy making art and creating children’s books, which combine my interests in mental health and parenting. Please feel free to ask me questions regarding my education, specializations, experience and professional orientation.

**Fees and Insurance**

My professional fee has already been discussed with you, as well as how arrangements may be made for payment. A therapeutic hour is 54–60 minutes in length and fees are payable at the time services are rendered.

**Confidentiality**

All communications between you and I will be held in strict confidence with the following exceptions:

1.You have signed an authorization allowing me to disclose information

2. You are in present danger of harming yourself, or committing physical violence to another person

3. You are in court ordered therapy; or your records are petitioned by the court

4. There is an issue of child, elder, or dependent adult abuse

5. In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers,

documents and other items and prohibits the therapist from disclosing to the patient that

the FBI sought or obtained the items under the Act.

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, I will not disclose information communicated privately to me by one family member, to any other family member without written permission.)

During the pandemic I am conducting remote therapeutic sessions from my home in North Carolina. Currently I use a private Zoom meeting method but if other technologies become preferable I may change over, so long as they are HIPPA compliant.

Billing for copays is done through Ivy, which is a HIPPA compliant billing software for therapists.

**Appointment Scheduling and Cancellation Policies**

Sessions are typically scheduled to occur one time per week at the same time and day if possible. Sometimes, I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, I would appreciate the courtesy of twenty-four hours notice; otherwise you will be charged your customary fee for that session, barring emergencies of course. If you are using insurance and cancel without notice, you will be charged the full insurance fee, not just the co-pay.

**Therapist Availability/Emergencies/General Policies**

I would be happy to respond to any questions or needs you may have in between visits and during my normal working hours. However, I will attempt to keep these contacts brief as most important issues are better addressed within the context of a regular face-to-face session. I check my voicemail several times throughout the day and will return your call as soon as possible. However, if you should have a mental health emergency and are unable to reach me, please call 911.

**About the Therapy Process**

It is my intention to provide services that will assist you in reaching your goals. Based upon the information you share, I will provide recommendations to you regarding your treatment and you have the right to agree or disagree with my recommendations. I believe that therapists and clients are partners in the therapeutic process. Periodically, I will provide feedback to you regarding your progress and invite your participation in this discussion. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result.

**Termination of Therapy**

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with me. We will discuss a plan for termination as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. These alternatives may include, among other possibilities, referrals, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement carefully and understand its contents. Please ask me to address any questions or concerns that you have about this information before you sign!

I, agree to these conditions. Name of Client (Please Print)

Signature of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Signature of Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date