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CONSENT TO TREATMENT

WELCOME**:** Psychotherapy is unique in that it is highly personal work and, at the same time, involves a contractual agreement. It is important that you have a clear understanding of how the therapeutic relationship can work and what each of us can expect.

LIMITS OF CONFIDENTIALITY: Therapy sessions between a psychologist and a patient are strictly confidential (barring supervision/consultation by a licensed psychologist) except under certain legally defined situations involving threats of self-harm or harm to another, and cases of child abuse, elder abuse, or abuse of otherwise dependent individuals. In the case of self-harm, I am ethically bound to inform those in a position to help, or to otherwise enlist methods to prevent self-harm or suicide. In the case of danger to others, I am required by law to notify the police and to inform any intended victim(s). In instances of child abuse, elder abuse, or dependent abuse, I must notify the appropriate social service agencies. Other situations that require me by law to reveal information about you to others without your permission include a legitimate subpoena by a court of law if you are being treated or tested by court order.

PSYCHOLOGICAL SERVICES: Psychotherapy has both benefits and risks. The benefits are specific to each individual and may include the resolution of specific concerns that led you to seek therapy, lessening of distressful feelings, symptom reduction, and improved relationships with others. Working toward these benefits requires active involvement on your part. Remembering or talking about unpleasant events, feelings, or thoughts may result in experiencing discomfort and strong feelings. For these reasons, it is possible to experience an increase in symptoms during the course of treatment.

COORDINATION OF CARE: It is often helpful to address mental health concerns through multiple methods of treatment (i.e., therapy and medications). It is your duty to notify me, both at the outset of treatment and ongoing, if you are receiving treatment of any kind which relates to our work together. If I determine that communication between me and your other providers would be beneficial, I may ask you to sign a “Release of Information” form granting me permission to release or exchange information and records pertaining to you and your treatment.

PAYMENT AND FEES: Together we will decide on an appropriate fee, which I will expect you to pay before the end of each session, or on a schedule otherwise agreed upon. If you wish to pay monthly, I will give you an invoice at the end of each month. If you wish to pay by check, please make it payable to: Tanya Peters. You are financially responsible for any fees/charges associated with returned checks.

APPOINTMENTS AND CANCELLATION POLICY: Individual sessions are 50 minutes in length. The time scheduled for your appointment is assigned to you and you alone. *If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice, or you will be financially responsible for the missed session. Provided I have another appointment time available, you may reschedule for another time during the same week without charge.*

TERMINATION: You have the right to terminate therapy at any time; however, planned termination can be a valuable part of the therapeutic process. For your benefit, I request that we have at least two in-person termination sessions to process the ending stages of treatment, assess progress, and address issues related to follow-up care or referrals.

HOW TO CONTACT ME: If you need to contact me between sessions, you may leave a message at any time of the day or night at (917) 903-4454. Please be aware that I cannot always be reached by phone immediately, however, I will make every effort to respond to your call in a timely manner. If an emergency arises and you need immediate assistance, call 911, or go to the nearest Emergency Room and inform them that you are in crisis.

If you have any questions regarding the above or any related issues, please mention them. If not, please sign and date below indicating that you have read, understood, and voluntarily agreed to the above conditions.

Patient's
Signature_____Date_____

Name
(please print)_____