

Psychotherapy Informed Consent and Financial Responsibility Agreement

Please read the following information carefully. This document outlines the terms, policies, and expectations of your psychotherapy treatment, as well as the financial agreement between you (the client) and the therapist.

1. Client Information

Client Full Name:

Date of Birth:

Phone Number:

Email Address:

2. Psychotherapy Services and Consent

Psychotherapy is a collaborative process between you and your therapist. While therapy can be beneficial, it may also bring up uncomfortable feelings and memories. There are no guarantees of what you will experience, but active participation is essential for the best outcome.

Confidentiality and its Limits

All information shared in your sessions is strictly confidential. Information will not be released to anyone without your written consent, with the following legal exceptions:

- Suspected abuse or neglect of a child, elderly person, or disabled adult.
- Reasonable suspicion that you present an imminent danger to yourself or others.
- A valid court order or subpoena issued by a judge.

3. Financial Responsibility and Cancellation Policy

By signing this agreement, you acknowledge and agree to the following financial terms:

- **Session Fee:** The standard fee for a 50-minute session is \$. Payment is due at the time of service.
- **Cancellation Policy:** If you need to cancel or reschedule, you must provide at least 24 hours' notice. Cancellations made with less than 24 hours' notice will be charged the full session fee of \$.
- **Insurance:** If you are using health insurance, you are responsible for knowing your benefits, co-pays, and deductibles. If the insurance company denies payment, you are fully responsible for the cost of the session.

4. Acknowledgment and Authorization

By typing or signing your name below, you certify that you have read, understood, and agree to the terms of this Psychotherapy Informed Consent and Financial Responsibility Agreement.

Client Signature (or Legal Guardian):

Date:

Therapist Signature:

Date: