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OUTPATIENT SERVICES CONTRACT / CONSENT TO TREAT

Welcome to Until All the Pieces Fit, LLC. This document contains important information about Until All the Pieces Fit, LLC professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next session. When you sign this document, it will represent an agreement between you and Until All the Pieces Fit, LLC.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the issues you hope to address. There is many different methods that may be used to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. For the therapy to be most successful, you will have to work on things talked about both during sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees as to what you will experience. Your first few sessions will involve an evaluation of your needs.

CANCELLATIONS

Twenty-Four hours (24) hours advance notice of cancellation is required to cancel a session. Otherwise, the credit card on file will be charged for the full session rate. Two consecutive canceled or missed sessions may result in a termination of the professional relationship. I agree that I will keep a current and active credit card on file and will inform my therapist prior to my session if my payment method changes.

Initials _____

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless agreed upon in writing before the session.

CONTACTING YOUR THERAPIST

Your therapist may not be immediately available by telephone or email. Your therapist will make every effort to return your call/email by the next business day.

In emergency arises please do not wait, contact emergency services by dialing 911 or go to the nearest emergency room.

CONFIDENTIALITY AND LIMITS

The privacy of all communications between you and your therapist is protected by law. Information about your treatment can only be released to others with your written consent, except in specific situations required by law.

Legal and Ethical Exceptions

Your therapist is legally or ethically required to disclose limited information in the following circumstances:

- **Court Orders:** In most legal proceedings, you have the right to keep your treatment confidential. However, if a judge issues a court order, your therapist is legally required to release the requested information. You are encouraged to consult an attorney before disclosing mental health information in any legal matter.
- **Abuse or Neglect:** Your therapist must report any suspected abuse, neglect, or endangerment of a child, elderly person, or disabled adult to the appropriate state agency. This includes physical, emotional, or sexual abuse, whether current or past, especially if another vulnerable person may be at risk.
- **Threats of Harm to Others:** If you make a serious threat to harm another person, your therapist must take protective action, which may include notifying law enforcement or the potential victim.

- **Risk of Self-Harm:** If you are in danger of harming yourself, your therapist may contact emergency services, family members, or others who can help ensure your safety.
- **Professional Consultation:** Your therapist may occasionally consult with other professionals to provide the best care. Identifying information will be omitted whenever possible, and consultants are bound by confidentiality.

Your therapist will make every effort to discuss any necessary disclosures with you whenever possible. If you have questions about confidentiality or its limits, please bring them up in session. For specific legal guidance, please consult an attorney, as confidentiality laws can be complex.

Consent to Treatment

I hereby consent, as the client or authorized representative, to receive behavioral health services, including counseling, psychotherapy, and/or psychological assessments. The provider responsible for my care has explained the proposed treatment plan, potential risks, and available alternatives.

I understand that confidentiality is a vital part of behavioral health services, and my provider is ethically and legally obligated to protect my privacy except as required by law.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Name: _____

Signature of Client / Authorized Representative: _____

Date: _____

Therapist Signature: _____

Date: _____