Turning Point Psychotherapy
Christine Hassell MA, LMFT
Christine@turningpointpsychotherapy.com

Thank you for your interest in Turning Point Psychotherapy.

Name: Email:

Ph: Date of Birth: Street Address:

City: State Zip Employer:

Emergency Contact: Phone:

Why are you seeking therapy at this time and what you would like to accomplish during your session?

How did you find Turning Point Psychotherapy?

Notice of Office Policies

Christine Hassell, LMFT no longer accepts insurance. HCF-1500 are provided upon request. 24 Hours notice is required to reschedule or cancel a session without charge except in documented cases of medical emergency.

Fees are $120 for 50 minutes. Fees are payable prior to time of service. Please make your payment to christine@turnintpointpsychotherapy.com via Paypal.

In the event of an emergency please call your local County Emergency Services. In the event of a life threatening emergency dial 911.

Confidentiality

The content of your therapy sessions are considered confidential and "privileged." However, there are limits to the privilege. These situations include:

- Suspected abuse or neglect of a child, elderly person or disabled person.
- If I believe you are in danger of harming yourself or another person or you are unable to care for yourself.
- If you report that you intend to physically injure someone the law requires your therapist to inform that person as well as legal authorities.
- A court order to release information as part of a legal involvement in litigation. (company litigation, etc.).
- In natural disasters whereby protected records may become exposed.
- For purposes of collecting a debt.
- When otherwise required by law.
- You may be asked to sign a Release of Information so that I may speak with other mental health professionals or family members.

Consent for Treatment

By signing below, you are stating that you have read and understood this statement and you

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and for treatment. I understand that I may withdraw from treatment at any time. **I understand and agree to abide by the policies stated above.**

Print Name

Signature **Date**