Believe in Hope Counseling, LLC
Deborah Stramella, MSW, LCSW, LCSW-C

Consent for Treatment Form

I, _____ consent to receive counseling services from Deborah Stramella, MSW, LCSW, LCSW-C, therapist at *Believe in Hope Counseling, LLC*. I consent to the terms outlined below:

Available services: *Believe in Hope Counseling* provides an array of counseling services including: Individual, family or couples counseling. Sessions can be conducted in person or via web based video conferencing.

Fee Schedule:

Individual counseling in person $125.00 for 60 minutes

Couples counseling in person $135.00 for 60 minutes

Family session in person $135.00 for 60 minutes

Teletherapy $100.00 for 60 minutes

Missed appointments, no show $50.00

Written Reports: $100.00

(Includes summary of services and treatment, diagnostic impressions, court reports, etc.)

Cancellation of Appointment: If you are unable to attend an appointment for any reason please call and cancel giving 24 hour notice. If the appointment is canceled with less than 24 hour notice you will be responsible for paying a $50.00 late cancel fee. This fee will need to be paid in full before the next therapy session.

Confidentiality: Professional ethics, State and Federal law (HIPPA) require confidentiality of information shared during all medical/mental health sessions. All client files will be kept confidential and only released once you have signed a consent form releasing the information to a specified party.

Duty to Report/Duty to Warn/Duty to Protect: As a licensed clinician I have a duty to report any allegation of child abuse or neglect as well as any allegation of abuse or neglect of a vulnerable adult. If there is an admission of proposed harm to another individual, I have the duty to warn that individual and contact the local police department. If an individual is actively suicidal and unable to contract for safety, I have a duty to protect and will contact safety officials (police, hospital, etc.) If any of these cases arise and law officials must be contacted, please note that your therapist will not receive your written consent to release confidential information.

Consent: By signing this Consent for Treatment Form as the client or guardian of the client, I acknowledge that I have read, understand and agree to the terms and conditions contained in this form. I have been given the opportunity to address any questions and/or request clarification for anything that is unclear. I am voluntarily agreeing to mental health treatment for myself, child, and/or family. I also agree to pay all fees associated with receiving counseling services.

Client's Printed Name	Date
Client's Signature	Date
Client/Spouse/Parent/Guardian Printed Name	Date
Client/Spouse/Parent/Guardian Signature	Date
Therapist Signature	Date