

Angela Costello  
Licensed Marriage and Family Therapist

CONFIDENTIALITY AGREEMENT  
AND INFORMED CONSENT FOR THERAPY SERVICES

Therapy is a process and each client's experience is different. When a client actively participates in therapy (attending sessions on a consistent basis, applying learned skills and tools between sessions, processing and exploring underlying issues), there is a greater probability of life-enhancing change individually and in other areas of a their lives. The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work and what each of us can expect.

There are no miracle cures. I cannot promise that your behavior or circumstances will change. I can promise to work very hard with you and to do my best to understand and support you as well as help you clarify what it is that you want for yourself.

All interactions between us will remain confidential unless you request in writing from me to release information regarding your therapy. There are certain exceptions to this: I am required by law and/or professional ethics to report suspicion of child abuse, elder and dependent adult abuse, intent to commit suicide, threats to do physical harm to yourself or another, and/or certain legal proceedings. While it is my legal responsibility to report any of the above incidents, it is my ethical responsibility to help you through these stressful times.

Sessions will be 45 minutes. Occasionally, you may have to miss a session. I may only charge you for a missed session if you do not notify me 24 hours in advance. I, in turn, will notify you when I have to miss a session. The fee for therapy is \$250. It is most convenient to pay electronically after each session (i.e. Zelle, credit card, etc). However, if you prefer to pay by check or to pay each month, I can provide a statement for you at the beginning of each month. Upon request, I will provide you with a receipt (superbill) for you to submit to your insurance carrier. Your carrier may reimburse you for out-of-network benefits directly.

I provide in-office and Telehealth sessions via video conferencing and phone calls. In the event that you participate in Telehealth sessions or communicate electronically via email or text, by signing below, you agree that you understand that confidentiality may be compromised due to the possibility that the internet and phone are not guaranteed to be secure, and that you understand the risk of this.

Ending relationships can be difficult. When it is time for you to end ours, I would like you to give at least two weeks notice so we can process our work together.

If you need to contact me between sessions, please text me at the number below. If a true emergency situation arises, call 911 or any local emergency room.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

Angela Costello  
Licensed Marriage and Family Therapist

PAYMENT AUTHORIZATION

\_\_\_\_\_  
Cardholder's Name

\_\_\_\_\_  
Cardholder's Street Address, City, State, Zip Code

\_\_\_\_\_  
Cardholder's Phone Number

\_\_\_\_\_  
Client Name (if not Cardholder):

Credit Card Information:

Type of Card: American Express - Master Card - Visa (please circle)

Credit Card Number:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Expiration Month/Year: \_\_ \_\_ / \_\_\_\_

Security Code on Back of Card: \_\_\_\_\_

Credit Card Billing Zip Code: \_\_\_\_

I hereby authorize Angela Costello, LMFT for charge(s) to the credit card below for psychological services rendered and will not dispute the charge(s) with my credit card company.

\_\_\_\_\_  
Client Signature

Angela Costello  
Licensed Marriage and Family Therapist

PERSONAL INFORMATION FORM

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Client Phone Number: \_\_\_\_\_

Current Occupation/Employer: \_\_\_\_\_

Emergency Contact Name/Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_

Home Address: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Who Lives With You: \_\_\_\_\_

Current Medical Concerns: \_\_\_\_\_

Current Prescribed Medications: \_\_\_\_\_

Prescribed By: \_\_\_\_\_

Current or Past Substance/Drug/Alcohol Use: \_\_\_\_\_

Any Major Losses/Traumatic Events in the Client's Lifetime: \_\_\_\_\_

Prior Therapist's Name/Prior Treatment and Dates: \_\_\_\_\_

Main reason for seeking therapy or coaching services now: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\*\*All information completed on these forms is confidential. It is intended for therapeutic purposes only for services provided by Angela Costello.