Melissa Tolman
Psychotherapy Services

Consent to Psychotherapy Services

PSYCHOLOGICAL SERVICES – RISKS AND BENEFITS

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems brought forward. Therapy involves the process of reflection and the capacity to engage in such therapeutic tasks. There are varied methods I may use to explore the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to actively work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since 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 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. But there are no guarantees of what you will experience. You have the right to end therapy services if you are not feeling comfortable to continue, or no longer wish to attend.

Our first few sessions will involve an evaluation of your needs. After completion of evaluation, we will discuss what our work will include and a treatment plan to follow, if you decide to continue with therapy. If you have questions about my procedures, we should discuss them whenever they arise.

DURATION OF SESSIONS

Individual, Couples and Family Sessions are 50 minutes, beginning at the time scheduled.

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a client and a therapist, and I can only release information about our work to others with your written permission.
However, there are a few exceptions:

- You authorize release of information with your signature
- You present a danger to yourself or others
- There is suspected Child, Elder, or Dependent Adult abuse or neglect
- If your records are subpoenaed by a court of law
- If you report that another medical professional (i.e. doctor, dentist, psychiatrist) has caused harm, it would be reported to their regulatory college or board

- Parents or legal guardians of non-emancipated minors have a right to access the client's records.
- Insurance providers and other third party payers may be given information that they request regarding services to the clients. The type of information requested may include types of service, dates and times of service provided, treatment plan, progress of therapy, summaries, etc.

FEE FOR SERVICE

The fee for psychotherapy sessions is $ _____ due at the end of each session.
You will be charged $_____ for missed sessions or late cancelations under 24 hours.
Payment is due at every session.

Returned Checks: There will be a $30.00 returned check fee

CANCELLATION OR MISSED APPOINTMENTS

There is a 24-hour cancellation policy. Unless agreed otherwise, you will be charged the full rate for a psychotherapy session if you do not notify to cancel within 24 hours of the scheduled appointment.

PROFESSIONAL RECORDS

Under PHIPA (Professional Health Information Protection Act) The laws and standards require that I keep treatment records for 10 years, or for 10 years from the clients 18th birthday. Records are kept safely locked in my office. You are entitled to receive a copy of your records, make changes to inaccurate information, or I can prepare a summary for you instead. If you wish to obtain a copy of your records, you must do so in writing with 2 weeks notice.

- The fee for a copy of your record is $ 100.00-200.00 depending on file.
- A written summary is $ 50.00
- Letters for Court or alternative letters $ 50.00- 100.00

Emergencies:

These services do not provide emergency support 24/7, so it is important that if you are in imminent danger please call 911 or your nearest emergency room.

DISCHARGE POLICY

I reserve the right to close your file if you miss 3 sessions in a row without a legitimate excuse. I also reserve the right to suspend therapy services if services are rendered and not paid for after 3 sessions.

CLIENT INFORMATION

Name(s): _____

Date of Birth: _____

Address: _____

Telephone number: _____

Referred by: _____

Consent for Treatment:

I authorize that my provider of mental health services carry out psychological assessments, treatments, and/or diagnostic procedures, which now or during the course of my treatment are advisable. I am aware of the therapist's policy, as well as my rights through treatment and the confidentiality guidelines.

Clients under the age of 16 requires a legal guardian/parent(s) signature.

Client Name (s) & signature (s): _____ _____ _____	Date: _____ _____ _____
Guardian Name(s) & Signature(s): _____ _____	Date: _____ _____
Provider Name, Signature and Credentials: _____	Date: _____

_____ Requested copy of Consent to Psychotherapy Services

_____ Declined copy of Consent to Psychotherapy Services