**CLIENT TREATMENT AGREEMENT**

**ABOUT DR. CURRY:** Marta Curry, Psy.D. is a licensed clinical psychologist in the state of Connecticut (Lic.No.3728). Dr. Curry’s psychology practice provides psychotherapy services for women and couples in an outpatient private practice setting.

Dr. Curry’s practice is completely independent and not affiliated with the private practices of other practitioners in this office.

**VOLUNTARITY:** Psychotherapy is voluntary and the client is free to terminate psychotherapy any time.

**CONFIDENTIALITY:** Information disclosed during assessment and treatment is considered confidential and will not be revealed to anyone without your written permission, except where disclosure is permitted by law and deemed to be in the best interests of the client. The following are the legally permissible exceptions to confidentiality:

1. When there is reasonable suspicion of child, elder or dependent adult abuse or neglect;

2) when the client presents a serious danger of violence to others or the property of others;

3) when the client presents a serious danger to harm him/herself;

4) pursuant to a lawfully issued subpoena.

5) with client written informed consent.

**Note**: If/when we communicate via mobile phone privacy problems may occur due to the nature of technology capable of capturing broadcast conversations and transmissions. E-mail correspondence is not considered to be a confidential medium of communication.

**CANCELLATIONS**: At least 24 hours advanced notice of cancellations is required for scheduled appointments. Your full session fee will be charged for missed appointments not cancelled 24 hours in advance.

**EMERGENCIES**: Dr. Curry is not available for emergency services. If you are at risk of harming yourself or someone else, or if you are having severe symptoms, please call 911 or go to your nearest emergency room. Dr. Curry will return all communication within 24 hours.

**PAYMENT FOR SERVICES**: In office sessions are $200 for 60 minutes.

Dr. Curry accepts cash, personal check, VISA, Master Card, or American Express. Payments are made at the end of each session.

**INSURANCE:** Dr. Curry is an out of network provider for all plans. However, if you have a policy that provides reimbursement, Dr. Curry can provide you with the required form to submit to your insurance company.  Please contact your insurance company for specifics on out of network coverage for more information.

**RECORDS**: Your records are confidentially maintained in storage with Dr. Curry upon your termination of services. Dr. Curry will store your files for a minimum of 7 years. Conjoint therapy records cannot be released without written authorization from all parties.

**OUR AGREEMENT**

**Client:**

My signature below indicates that I have read and discussed this agreement. I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with you before ending therapy with you.

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

I have had my questions, if any, fully answered. I agree to act according to the points covered in this form. I hereby agree to enter into therapy with this therapist and to cooperate fully and to the best of my ability, as shown by my signature here.

Client Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinician:**

I, the clinician, have met with this client for a suitable period of time, and have informed him/her of the issues and points raised in this form. I have responded to all of his/her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent to treatment.

Clinician’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marta Curry, Psy.D.