

WELCOME TO MY PRACTICE. I LOOK FORWARD TO WORKING WITH YOU

Consent for treatment

The process of therapy/evaluation:

Psychotherapy has potential benefits for you. You will be invited to present the reasons that bring you for treatment and to offer your feedback and your views with respect to therapy and how your therapist responds to you. This is a mutual process where each of us is responsible for helping to accomplish the resolution of the circumstances for which you have requested help. As the process unfolds, remembering or talking about certain events, feelings or thoughts might result (but not limited) in any of many feelings. Among some of the feelings that might be experienced are sadness, anger, anxiety and joy. You are invited to articulate any and all thoughts and feelings that occur during the course of treatment. You are also invited to ask for help to speak about material that may be more difficult for you. Talk therapy has shown, over many years its potential to be helpful: however, no warranties or implication with respect to any outcome are guaranteed or promised.

Treatment plan:

Your treatment plan is individualized and reflects our mutual discussed goals. This plan might include referral to other professionals.

Confidentiality:

All information discussed in your therapy session is strictly confidential. This includes verbal communication as well as written material pertinent to those sessions. This information cannot be revealed to anyone without your written consent except for the following exceptions required by law:

- 1) Information about child abuse of elderly or disabled adult.
- 2) You are a threat to yourself or others (suicide, homicide threats or intent).
- 3) Court order to present records in case of a lawsuit.

Medical Care:

It is very important that your state of physical health is understood. Accordingly, unless you are simultaneously in treatment with a physician it is required that you have a physical examination to insure that none of the symptoms that bring you to this office have any relationship to physical causes. This is because some medical conditions can mimic psychological symptoms. Unless specifically prohibited by you, your signature to this agreement authorizes us to communicate with any or all health care providers, without restriction, so that we may be fully informed as to your state of health.

Medical professional : _____ Tel _____

Medical professional: _____ Tel _____
Psychotherapist _____ Tel _____

Health Insurance and Confidentiality of Records:

Signing an insurance claim is granting permission for a release of information about your treatment, including diagnosis, to the insurance company. This information becomes part of your medical record. Unless authorized by you explicitly, your psychotherapy notes will not be disclosed to your insurance carrier.

Insurance:

Your insurance company may have limited benefits that could directly affect your financial ability to stay in therapy. **We recommend and see it as YOUR responsibility to contact your insurance company to determine whether and how much benefits are available to you as well as the limitation of your contract with your insurance company.** Should loss of benefits result, it is understood that Naomi Berger is under no obligation to provide further treatment unless payment continuous in full from you, or according to the agreed fee. I will assist you in the filing of insurance claims, if you request, however, the charges for the service are your responsibility irrespective of what your insurance company pays. Insurance co. _____

This therapist has a certain therapy appointment slots for insurance contracted patients. Unless it is mutually agreed from the beginning that she will accept what insurance allows as payment in full, your session will be charged the private full fee. This might include the difference between your insurance allowance and Naomi's full fee charge(_____). Insurance assignment is not accepted as a full payment for sessions scheduled after office hours. Naomi will gladly assist you in filing your insurance claims, payments of which will be fully reimbursed to you. You will be notified at your initial session if your insurance assignment is accepted as full payment for your treatment. Your signature below indicates that you have understood, agreed and accept these terms of your treatment contract.

Fees:

A fee of \$_____ for one hour session is to be paid at the time of service or according to a payment plan agreed upon with your therapist. Should the session duration increase over the agreed upon time, you will be notified that the session has ended and that additional fee on pro rated basis will be charged. Fee covers time spent in therapy session. Should time be needed for special reports, consultation with other professionals, or other persons connected with your treatment or other services in addition to the agreed upon psychotherapy/counseling services, it is understood that such services may be

subject to additional charges. NO additional charges will be imposed without prior consent.

Cancellation:

A scheduled appointment is time reserved specifically to you. If you cannot attend a session, you need to cancel 24 hours prior to your session. You will be charged the full fee for the session that are broken or cancelled at the last moment. Insurance companies do not allow and do not pay for missed sessions.

Litigation Limitation:

It is agreed that unless required by law, or otherwise agreed by this therapist, in event of legal proceeding of any sort, your therapist will not testify in court or at any proceeding regarding your treatment. This includes providing psychotherapy papers.

Emergencies:

If true emergency exists, please call 911 or go to the nearest emergency room. If you need to contact us, please call the office at the regular office hours. If you attempt to reach this therapist while she is in session, please note that phone calls are not accepted until the session ends. Your call will be returned as soon as your therapist is able to retrieve your message. In the event that you need to speak with your therapist after hours, this therapist will do her best to be available, however, we do not provide 24hour crisis response.

By affixing my/our signature(s) I/we acknowledge that the terms and conditions noted herein are clear and agreeable and that I/we have given an opportunity to ask any questions.

Patient Name _____

PRINT

Patient Signature _____ Date: _____

Patient Name _____

PRINT

Patient Signature _____ Date _____