RISE CENTER FOR PSYCHOLOGY

INFORMED CONSENT (ADULT)

GENERAL: I am very pleased to have the opportunity to work with you. This document contains very important information about my policies and by initialing/signing below, it will represent an agreement between us. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular problems 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 work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, etc. On the other hand, psychotherapy has also been 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 as to what you will experience. By the end of the first few sessions, I will be able to offer you some first impressions and concurrently you should be able to determine if you think this process will work for you. If you have questions about my procedures, we should discuss them whenever they arise.

Initials: Client (18 and older) _____

CONTACT: I am often not immediately available by telephone. When I am unavailable, my office telephone is answered by a voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the possible exception of weekends and holidays. In emergencies, you can always text or call me on my cell phone. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Initials: Client (18 and older) _____

PAYMENT: My fees will be discussed privately with you, either prior to, or during, our first appointment. Payment in full is expected at the time of service, or according to a mutually agreed upon schedule with me. In addition to weekly appointments, I charge for other professional services you may need, such as report writing, telephone conversations, email dialogues, attendance at meetings with other professionals that you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request. Your account is expected to be paid in full at the end of each month. Most health insurance policies will cover some portion of mental health treatment. I do not participate as an "in-network" provider. I will be happy to help you understand any questions you may have regarding your insurance policy; however, I do not submit bills to insurance companies, and you (not your insurance company) are responsible for full payment of my fees.

Initials: Client (18 and older) _____

CANCELLATION POLICY: Once an appointment is scheduled, I have a strict 24-hour notice for cancellation. This reasonable prior notice of cancellations permits us to better accommodate our other clients' needs. Except in cases of family/medical emergency and illness, appointments cancelled within 24 hours will be charged full fee for the appointment. These fees are not covered by health insurance and are the client's personal responsibility.

Initials: Client (18 and older) _____

PRIVACY: Confidentiality is your right and our duty. In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. The privacy of all records pertaining to your treatment will be maintained securely by us. Records will be kept for a minimum of seven (7) years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, as provided for by Illinois and Federal law. You have the right to review your records (including the record of disclosures made) upon your written request. We charge a reasonable fee for copying records requested by you. If at any time you feel your privacy has been violated, you have the right to file a grievance with us and/or with the Secretary of the U.S. Department of Health and Human Services. Note, however, that the law requires the release of otherwise confidential information when the provider reasonably believes disclosure is necessary to protect against harm to yourself or others, when there is suspicion of child or elder abuse, and when records are demanded by Court Order.

Initials: Client (18 and older) _____

THANK YOU/NEWSLETTER: If you have any questions, please do not hesitate to ask. Your initials above indicate that you have agreed to the policies and your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

CLIENT SIGNATURE: _____ **DATE:** _____

Also, *please let us know if you would like to be added to our monthly newsletter by adding your email(s) below.* Thank you.

Email: _____ Email: _____