

CLIENT INFORMATION

Name _____

Address _____

Telephone: Home _____ Work _____ Cell _____

Date of Birth _____ Age _____ Marital Status S M D Sep

Referred By _____

<u>Who currently lives at your residence</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list previous counseling experiences for you or family members (include therapists' names and dates): _____

<u>All Current medical diagnoses</u>	<u>All Medications</u>	<u>Dosage (amount/day)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
<u>Previous Hospitalizations (location)</u>	<u>Reason</u>	<u>Dates</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact (name) _____ phone _____

Your Current Occupation, Place of Work, and Work Address _____

Date

Please initial

CHECKLIST OF SYMPTOMS

Please check all that apply to how you are feeling.

- Sad or blue most of the day, nearly every day
 - Lost interest in activities you once enjoyed
 - Have problems with insomnia
 - Have problems with oversleeping
 - Recently experienced a significant gain in appetite
 - Recently experienced a significant loss in appetite How much? _____
 - Feel agitated
 - Feel irritable
 - Feel anxious
 - Feel angry
 - Experience feeling on edge
 - Feel paranoid
 - Have panic attacks
 - Feel tired or fatigued
 - Poor social skills
 - Suffer from feelings of inappropriate guilt
 - Suffer from feelings of hopelessness
 - Suffer from feelings of inadequacy
 - Recently experienced a loss of energy and motivation
 - Have difficulty concentrating
 - Have slowness of thought or speech
 - Have suicidal thoughts
 - Feel your heart race
 - Have sweaty palms
 - Feel nervous much of the time
 - Experience chronic fatigue
 - Experience wild mood swings
 - Feel hostile or act abusively
 - Lie chronically
 - Suffer from domestic violence
 - Have problems in school or at work
- If so, please list:
- Suffer from feelings of helplessness
 - Hallucinations

List any other symptoms you think are important:

Initial this page

How many alcoholic drinks do you have per week?
 0 – 1 2 – 5 more than 5

How many DWI/DUI's have you received? _____

Do you ever feel the need to cut down on drinking? Y N

Have you ever received comments, criticism regarding your drinking? Y N

Have you ever felt guilty about your drinking? Y N

Have you ever awakened the morning after some drinking the night before to find that you could not remember part of the evening before? Y N

Do you drink before noon? Y N

Have you ever felt the need for an Eye Opener when you first get up in the morning or first thing in morning? Y N Prior to social events? Y N

What non-prescription drugs do you use other than alcohol?
 How many times a week do you use?
 0 – 1 2 – 5 more than 5

When do you use?
 Before breakfast morning afternoon at night weekends only

Have you ever felt the need to cut down on drug use? Y N

Have you ever received comments, criticism regarding your drug use? Y N

Have you ever felt guilty about your drug use? Y N

Please describe ***past*** alcohol/drug use: list all substances used, degree of intensity, dates used, last date used

Initial this page _____

Please check the highest level of education you have attained:

- | | |
|---|--|
| <input type="checkbox"/> High School | <input type="checkbox"/> Graduate work |
| <input type="checkbox"/> GED | <input type="checkbox"/> Master's degree |
| <input type="checkbox"/> Some college (how much?) | <input type="checkbox"/> Ph.D. |
| <input type="checkbox"/> Bachelor's degree | |

Please list any significant psychiatric and physical disorders in the family in which you grew up – father, mother, siblings, aunts, uncles, cousins:

Please list any traumatic events that occurred during your childhood:

Please list any past or present substance use by family members (your family now and the family in which you grew up):

Please briefly describe your current concern that brings you to counseling:

Date

Signature

Marguerite (Rita) Hursh, LPC
5675 Stone Road, Suite 300
Centreville, VA 20120
Telephone: 703-715-6077

Authorization to Apply for Insurance Benefits

Client Information: **Date:** _____

Client Name _____

Home Address _____

Home Phone _____ work phone _____ cell phone _____

Date of Birth _____ Age _____

Insurance Information:

Primary Insurance Company Name _____

Address of Insurance Company _____

Phone Number of Insurance Company _____

Name of Policy Holder _____

Policy Holder Date of Birth _____

Insurance ID or Policy # _____ Group Code _____

Type of Policy (e.g., PAR or PPR) _____

Secondary Insurance Company Name _____

Secondary Insurance Company Address _____

Insurance Company Phone Number _____

Name of Policy Holder _____

Insurance ID or Policy # _____ Group Code _____

I certify that I, and/or my dependent(s), have insurance with _____ (name of insurance company(ies)) and assign directly to Rita Hursh, LPC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges if not paid by insurance. I authorize the use of my signature on all insurance submissions. I give permission for Rita Hursh, LPC, to use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Authorized Signature _____

Please print name _____ Date _____

Marguerite (Rita) Hursh, LPC
5675 Stone Road, Suite 300
Centreville, VA 20120
703-715-6077

Consent to Use or Disclose Information for Treatment, Payment, and Health Care Operations (TPO)

Client Name _____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as “health care operations”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise my Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I, _____, hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Client: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

*Marguerite “Rita” Hursh, LPC
5675 Stone Road, Suite 300
Centreville, VA 20120
Phone: 703-715-6077*

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law, I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it on my website, www.ritahursh.com or in my office, which is located at 5676 Stone Road, Suite 300, Centreville, VA 20120.

III. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

I. For treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to her/him in order to coordinate your care.

2. For health care operations. I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control – I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment. I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures. Examples: Your consent isn't required if you need emergency treatment, provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement. Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

2. If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

3. If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

4. If disclosure is compelled by the client or the client's representative to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

5. To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

6. If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

7. If disclosure is mandated by the Virginia Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.

8. If disclosure is mandated by the Virginia Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. For health oversight activities. Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. For specific government functions. Examples: I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.

13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

14. For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.

15. Appointment reminders and health related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options, or other health care services or benefits I offer.

16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. I am permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health benefits and services that may be of interest to you.

18. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

19. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosure Require You to Have the Opportunity to Object.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

A. The right to see and get copies of your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than \$.50 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

B. The right to request limits on uses and disclosures of your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

C. The right to choose how I send your PHI to you. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, to be picked up instead by regular mail). I am obligated to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience.

D. The right to get a list of the disclosures I have made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement

personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E. The right to amend your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

V. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact me at: Marguerite Hursh, LPC, 5675 Stone Road, Suite 300, Centreville, VA 20120.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice.

Client Name: _____ Date: _____ Signature: _____
(Please print)

Client Name: _____ Date: _____ Signature: _____
(Please print)

Client Name: _____ Date: _____ Signature: _____
(Please print)

Office Policies & General Information Agreement for Psychotherapy Services

This form provides you (client) with information that is additional to that detailed in the Notice of Privacy Practices.

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

When Disclosure Is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also Notice of Privacy Practices form).

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Rita Hursh ("Provider"). In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Provider will use her clinical judgment when revealing such information. Provider will not release records to any outside party unless she is authorized to do so by **all** adult family members who were part of the treatment.

Emergencies: If there is an emergency during our work together or in the future after termination, where Provider becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided on the biographical sheet.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you so instruct Provider, only the minimum necessary information will be communicated to the carrier. Provider has no control or knowledge over what insurance companies do with the information she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the congressionally approved National Medical Data Bank. Accessibility to

companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access.

Confidentiality of E-mail, Cell Phone and Faxes Communication: It is very important to be aware that e-mail and cell phone communication can be relatively easily accessed by unauthorized persons, and hence the privacy and confidentiality of such communication can be compromised. Please notify Provider at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above-mentioned communication devices. Provider does not use e-mail to correspond with or about clients.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney, nor anyone else acting on your behalf will call on Provider to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation: Provider consults regularly with other professionals regarding her clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact Provider between sessions, please leave a message on the voice mail, and your call will be returned as soon as possible. Provider checks her messages several times a day unless she is out of town. When Provider is out of town, she arranges for calls to be covered. If an emergency situation arises, please indicate it clearly in your message. **If you need to talk to someone right away, you can call 911 or go immediately to the nearest emergency room.**

PAYMENTS & INSURANCE REIMBURSEMENT: Clients are expected to pay the standard fees of \$150 for initial intake session and \$130 per 50 minute session at the beginning of each session, unless otherwise stipulated by an insurance co-pay. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate, unless indicated and agreed otherwise. **A 24-hour cancellation is necessary to avoid a \$130 charge. Only in the case of an emergency (as defined by Provider) will the \$130 charge be waived.** In case of **snow and ice**, all sessions will be held unless cancelled by telephone by either client or therapist. Clients who do not call to cancel will be charged the \$130 charge. Clients who carry insurance for which Provider is out of network should remember that professional services are rendered and charged to the client and not to the insurance companies. Unless agreed upon differently, Provider will provide you with a copy of your receipt on a monthly basis, which you can then submit to your insurance company for reimbursement if you so choose. As was indicated in the section, *Health Insurance & Confidentiality of Records*, you must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/conditions/problems, which are the focus

of psychotherapy, are reimbursed by insurance companies. ***It is your responsibility to verify the specifics of your coverage.***

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Provider views therapy as a partnership and will ask for your comments and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Provider may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors regarding employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, Provider is likely to draw on various psychological approaches according, in part, to the problem that is being treated and her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), psycho-educational, or emotionally focused therapy.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment Provider will discuss with you her working understanding of the problem, treatment plan, therapeutic objectives, and her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, Provider's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that Provider does not provide, she has an ethical obligation to assist you in obtaining those treatments.

Termination: As set forth above, after the first couple of meetings, Provider will assess whether she can be of benefit to you. Provider does not accept clients who, in her opinion, she cannot help. In such a case, she will give you a number of referrals that you can contact. If at any point during psychotherapy, Provider assesses that she is not effective in helping you reach the therapeutic goals, she is obligated to discuss it with you and, if appropriate, to terminate treatment. In such a case, she will give you a number of referrals that may be of help to you. If you request it and authorize it in writing, Provider will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another

therapist, Provider will assist you in finding someone qualified, and if she has your written consent, she will provide that therapist with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, Provider will offer to provide you with names of other qualified professionals whose services you might prefer.

Dual Relationships: Not all dual relationships are unethical or avoidable. Consequently, you may bump into someone you know in the waiting room or run into Provider out in the community. Provider will never acknowledge working therapeutically with you without your written permission. It is your responsibility to communicate to Provider if the dual relationship becomes uncomfortable for you in any way. Provider will always listen carefully and respond accordingly to your feedback. Provider will discontinue the dual relationship if she finds it to interfere with the effectiveness of the therapeutic process or the welfare of the client and, of course, you can do the same at any time.

Cancellation: Since scheduling of an appointment involves the reservation of time specifically for you, a **minimum of 24 hours (one day) notice is required** for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. **Insurance companies do not reimburse for missed sessions.**

I/We have read the above Agreement and Office Policies and General Information carefully; I/we understand them and agree to comply with them:

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____