Jennifer McMillan, LMFT, LMHP

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INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name:_____ Date of Birth_____
Address:_____
Best number to reach you:_____
Email address:_____

I prefer:
___ not to communicate through email
___ to use email only for scheduling appointments
___ I understand that the use of email may not be confidential

As your therapist, it would be unethical for me to have a relationship with you outside of our therapeutic relationship. This includes social networking sites.

Treatment Philosophy:

Welcome! I look forward to our time working together. Psychotherapy has both benefits and risks. It requires an investment of time and energy in order to make the process most successful and beneficial. Occasionally clients may go through periods of increased stress in therapy, which may result in emotional discomfort, changes in relationships, or temporary worsening of symptoms. This should subside as the work progresses. I cannot guarantee that treatment will be successful. If I determine that I cannot provide the treatment you need, I will refer you to a list of alternative providers. I may also make other appropriate referrals if I find it necessary (i.e. psychiatric evaluation). Remember, you always retain the right to request changes in treatment or to refuse treatment at any time.

Client Rights:

1. You have the right to be informed regarding the terms under which treatment will be provided.
2. You have the right to know my qualifications and training.
3. You have the right to terminate treatment at any time and for any reason.

By signing this form, I agree to the following policies:

Confidentiality:

I understand that all information shared with the clinician is confidential and no information will be released without my consent. Consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take steps to prevent such danger. When there is suspicion that a child or elder is being sexually, physically, or emotionally abused or neglected or is at risk of such abuse, the clinician is legally required to take steps to protect the child and inform the proper authorities.

When a valid court order is issued for medical records, the clinician is bound by law to comply with such requests.

Insurance:

I do not bill insurance. However, I will happily support you in requesting reimbursements or accessing third party payments when available. I will provide a statement of services upon request. If you have insurance, you will need to find out whether you have mental health benefits. Some insurers only allow you to see a provider on their panel; other insurers will allow you to see any licensed professional.

Appointments:

I understand that sometimes cancellations/rescheduling is necessary. Please provide me with 24-hour advanced notice. Without the advanced notice you will be charged for the missed appointment ($100).

Financial Responsibilities:

Payment is collected at the time of the appointment. Cash and check are preferred. My fee is $100 per session, and sessions are 50 minutes in duration.

I agree, understand, and will comply with the above terms and conditions of services.

_____ _____
Client/Guardian Date

_____ _____
Jennifer McMillan LMFT, LMHP Date

I have read and been offered a copy of the HIPPA Privacy Practices.

_____ Date_____