CONSENT FOR TREATMENT

Welcome to my practice. Therapy can be an extremely rewarding experience and it is important to understand some of the things you can expect as we begin working together. The following guidelines should help. Should you ever have any questions or concerns about the information contained in this consent, please do not hesitate to share them with me.

The experience of psychotherapy is different for every individual which depends on a variety of factors, including the particular problem or desired goal, background, experiences, etc. Talking about difficult issues can lead to painful feelings from the past as well as other challenges in life. By being an active participant and working on things we discuss in session there is a likelihood that your relationships and quality of life will improve including a reduction of stress and frustrations.

CONFIDENTIALITY:
Communication between therapist and client is both privileged and confidential. This means that I cannot discuss your case orally or in writing with anyone. Our communications will remain confidential unless you request otherwise by signing a "Release of Information". There are certain exceptions to this, which I have listed below. A psychotherapist has an ethical and legal obligation to break confidentiality under the following circumstances:
-If there is a reason to believe there is an occurrence of child, elder, or dependent abuse or neglect.
-If there is reason to believe you have a serious intent to harm yourself, someone else, or property by a violent act you may commit.
-If you introduce your emotional condition into a legal proceeding or I am subpoenaed to give testimony.

Consultation:
Therapists often refer to colleagues for consultation to provide the best possible treatment. Your confidentiality is very important and your name or any identifying information is never used.

FEES/APPOINTMENTS/CANCELLATIONS:
Standard individual sessions are 50-minutes ($185) and couple sessions are 75-105 minutes, ($275-$325) payable at each session unless we have made other arrangements. At times I may offer a lesser fee in order to accommodate your ability to pay. We will spend some time in your first session agreeing upon a fee that feels respectful, realistic and reasonable to us both. Then we will re-evaluate the fee whenever circumstances (yours or mine) warrant a fee change. I accept credit cards, cash, or checks. Please make checks payable to Tracey Harvey, MFT.

We will decide together upon a specific day and time for your session(s). I will set the time aside for you and will not give your time to anyone else. To avoid paying for missed sessions. I require 24 hours advance notice if you are unable to keep your appointment. Of course, allowances will be made for illnesses or serious emergencies. If you cannot attend a session for any other reason, I will try to reschedule you for that week.

Deciding the best course of treatment is a decision that should be made between you and I. So that such decisions are not influenced by an insurance company, I have chosen not to be an in-network provider for any carrier. This further protects my clinical independence and your confidentiality.

If you choose to use insurance, as a licensed marriage & family therapist my services are covered under most insurance plans for which you can utilize out of network coverage. Should you wish to bill your insurance, I will provide you with monthly statements ("superbills") with the necessary information for you to seek reimbursement. You may want to consult your insurance provider as reimbursement rates vary from plan to plan, and may change based on diagnosis.

Any fees which remain unpaid for over 60 days are subject to legal action, which may involve hiring a collection agency or going through small claims court.

CLIENT RIGHTS AND RESPONSIBILITIES:
In addition to your right to confidentiality, you have the right to end your therapy at any time, for whatever reason, without any obligations except for the fee already incurred. You also have the right to question any aspect of your treatment and expect that I will maintain professional and ethical boundaries with you, not entering into any personal, financial or professional relationships with you which could compromise the therapeutic relationship.

Please sign this consent for treatment, indicating that you have read, understand, and agreed the above.

Name of client_____

Signature of client_____

Date_____

Intake Questionnaire

Name:_____DOB:_____

Address:_____

City:_____State:_____Zip:_____

Cell phone:_____Home:_____Work:_____

Email address:_____

Do you have any current or past medical conditions? _____No _____If Yes, please explain:

_____

Do you have any current or past mental health conditions?_____No ____If Yes, please explain:

_____

Are you currently taking any medications? _____No _____If Yes, please list:

_____

How would you rate your physical health? _____

Do you consider yourself to be spiritual or religious?_____No_____If Yes, please explain:

_____

How would you rate your current sleeping patterns- On a scale of 1-5 (1-poor—5-very good)_____

List any specific sleeping problems_____

Are you currently employed? _____No_____If Yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about it?_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in?_____

Please list any difficulties you experience with your appetite or eating problems._____

Are you currently experiencing any sadness or grief?_____If so for how long?_____

How much alcohol do you drink in a week?_____

How often do you engage in recreational drug use?_____

Are you currently in a romantic relationship? If yes, for how long.

On a scale of 1-10 (1-poor and 10 being exceptional) how would you rate your relationship?_____

What significant life changes or stressful events have you experienced lately?_____

What do you consider to be some of your strengths?_____

What do you consider to be some areas of weakness_____

What would you like to accomplish out of your time in therapy?_____

Credit Card Authorization

Client Name: _____

Cardholder Name: (if different than client)_____

Billing Address: _____

City_____ZIP_____

Credit Card Type: _____Visa _____Master Card _____Discover

Credit Card Number: _____

Expiration Date: _____

Security Code: (last 3 numbers on back of card) _____

I authorize Tracey E. Harvey, LMFT to charge the agreed upon amount to my credit card provided herein. I understand that my card will be billed the day of the session, including days of missed sessions and/or cancellations within 24 hours notices, as explained on the Consent for Services. I agree to pay for this amount in accordance with the issuing bank cardholder agreement.

Cardholder Signature: _____

Date: _____