Conditions of Treatment and Consent to Treatment

- I understand that the fee for services rendered is $120.00 dollars per session. This fee or my insurance co-pay/deductible is due at each appointment. I understand that time is reserved for my appointment. If I miss an appointment, I am responsible for the full fee unless I have given 24 hour notice. I understand that missed appointment fees are not reimbursable by insurance.

- If I use my insurance to pay for all or part of my treatment, I authorize disclosure of my confidential information to the billing services and my insurance company. I understand that I am responsible, not my insurance company, for full payment of fees. I agree to pay for any sessions not paid for by my insurance company, for any reason.

- I understand that for psychiatric or extreme life threatening emergencies. I will go to the nearest emergency room or call 911. For less urgent calls I will contact Trish preferably on both her office and cell phones, listed above. I understand Trish will be available to me at her earliest convenience but may not be immediately available due to the nature of a solo practice.

- I agree to report any dissatisfaction with my therapy to Trish. I agree that if I want to terminate treatment, I will schedule a last session to finalize the work.

Issues at Confidentiality

Issues discussed in therapy are confidential with the following **exceptions.** I understand that Trish Garrison, LICSW:

- may be mandated by law to report and take action to prevent a clear immediate danger to myself or other persons; to report suspicion of abuse, neglect or mistreatment of minors or incapacitated/ dependent adults; to report abuse by a medical professional, clergy or other professional in whom I or other persons have sought treatment.
- may participate in individual or group consultation attended by other professionals. I understand that BY SIGNING THIS I agree that aspects of my work may be discussed for learning purposes and that my identity will never be disclosed.
- is an individual practitioner, does not belong to a group practice and is not connected to other providers, not even those who share this office space or have offices in this building.

I have read, understand and agree to the above conditions and exceptions. I have received a **Notice of Privacy Practices and Practice Policies** and a **Summary of Notice of Privacy Practices.**

Signature ____

Date:______________________

Printed Name: ____