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Psychological Consultation
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INFORMED CONSENT FORM

Welcome to my practice. This document addresses questions that commonly arise in the beginning of psychotherapy, and clarifies certain policies and procedures that are specific to my practice. I ask that you read and sign this document in order to indicate your understanding of office procedures and your willingness to abide by these policies. I will provide you with a copy of this document so that you are able to refer to it as needed.

I am a licensed clinical psychologist. I utilize a predominantly cognitive behavioral approach to treatment but may use other strategies if deemed appropriate. I understand and respect that psychotherapy involves a large commitment of time, money and energy and, as such, you must feel comfortable with me as the therapist. Psychotherapy is a highly collaborative process requiring consistent effort, and much of the work often occurs between sessions. As with any powerful treatment, there are benefits and risks associated with psychotherapy. Some possible benefits may include improved interpersonal behavior and relationships, diminished stress, and greater professional or academic success. Risks may include, among others, temporary increases in feelings such as sadness, anger, and anxiety or the recalling of unpleasant aspects of your history. I only accept patients that I believe I can help. If at any point you feel dissatisfied with my clinical approach or its results, please discuss this directly with me so that changes, if appropriate, can be made to meet your needs. If necessary, I can refer you to another mental health professional for consultation and/or treatment.

Office Hours

Psychotherapy sessions are scheduled by appointment only. If you need to reach me between regularly scheduled appointments, you can leave a message at (301) 530-0077. My voice mail is confidential and I check for messages regularly each day. Information can also be faxed to me at (301) 530-5323. Routine phone calls are generally returned within 24 business hours; however, in the event of a life-threatening emergency, or if you feel unable to wait for a return call, please dial 911 or go to your nearest emergency room to obtain immediate assistance.

Professional Fees

Payment is due at the time of your visit, and this fee is $375 for the 60-minute initial consultation. For future visits, the standard fees are $225 for the typical 45-minute session, $275 for a 60- minute, and $175 for a 30-minute. Telephone consultations over 10-minutes in length may be billed at a prorated fee at my discretion. If there are legal matters that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $550 per hour for preparation, travel, and attendance at any legal proceeding. Please note that fees are subject to change.

A statement will be mailed or given to you at the end of each month for all services provided during that month. Payment is due on receipt of this statement and no later than the 15th day of the next month. Failure to adhere to this system may result in payment being due at the time of each appointment or, if necessary, in discontinuing non-emergency services until any outstanding balance is paid.

Session Information and Cancellation Policy
At the beginning of treatment, you and I will agree on a regular meeting time. Please note that that session time slot will be considered solely yours and as this time cannot be offered to or shared with anyone else, 24 hours advance notice for cancellation of a session is required. If you cancel a session with less than 24 hours notice, the full fee will be charged. Please note that insurance companies usually do not provide any coverage for missed appointments.

Confidentiality
Generally speaking, information shared by a patient during psychotherapy is confidential and will not be disclosed without both verbal and written consent, unless required by law, or as noted below. While I do participate in peer consultation and review, any clinical discussion is conducted with a full effort to maintain confidentiality and anonymity. During planned absences or emergencies that may keep me away from the office, I may request coverage from an another mental health professional, and that colleague may be given your name, if necessary, in order to make it easier for you to contact them in an emergency. Other exceptions to confidentiality, as specified either by my profession's ethical standards or by state law, include when I believe that you or your child intends to harm him/herself or another person and when I believe that a child, elderly person or disabled individual is or has been subject to abuse or neglect. In some other rare and special circumstances, confidentiality may be compromised. If any such situation arises, I must notify the appropriate authorities or individuals in order to protect anyone at risk but will also make every effort to discuss the situation fully with you prior to taking any action. Finally, insurance companies sometimes require information regarding your symptoms, diagnoses, and treatment plan; any such information will only be provided with your consent.

Social Media
Please note that I do not accept friend or contact requests from current or former patients on any social networking site (e.g., Facebook, LinkedIn, etc.). I believe that taking these actions could compromise your confidentiality and our respective privacy as well as blur the boundaries of our therapeutic relationship. If you have questions about this policy, feel free to bring it up when we meet so we can discuss it further.

I look forward to providing you with a positive and rewarding therapy experience. Please feel free to ask any questions that you have concerning all information provided above. By signing below, you are indicating that you both read and understand all practice policies and agree to all conditions stated within this document.

Even though there are other names of mental health professionals on the door and on other materials in this office, please be advised that I am engaged in independent practice and am *not* in any professional partnership or corporation with other persons who also do business at 6312 Democracy Boulevard.

IN CONSIDERATION OF SERVICES RENDERED AND TO BE RENDERED, I GUARANTEE PAYMENT FOR ALL CHARGES INCURRED.

Patient's Name/Signature____________________________________ Date____________________

Parent's Signature ____ Date___________________
(if patient is a minor)

Parent's Signature ____ Date___________________
(if patient is a minor)