Suzanne La Placette, Ph.D., LMFT

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Informed Consent

Name: _____

D.O.B._____ Age:_____

Address:_____

City:_____ Zip Code:_____

Home Phone:_____

Mobile Phones: _____

Email Address: _____

Mailing Address (if different):_____

_____

In the Event of an Emergency Contact:_____

Telephone Number:_____ Relation:_____

Psychotherapy Service Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Psychological Services

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first several sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. I, too, will assess your needs and if I believe that you would benefit from seeing a different therapist I will advise you of this and assist by providing you with referrals. If you have questions about my procedures, we should discuss them whenever they arise.

Cancellation Policy:

To avoid paying for a missed session I will need to be informed **72 hours** prior to your appointment that you will not be attending. In the event that you do not cancel your appointment **72 hours in advance*, I will do my best to reschedule your appointment to another hour within the same week*.** Therefore, it is best if you advise me as soon as possible of any conflict with your appointment so that options exist for rescheduling. ***In the event that another time is not available within the same week, you are financially responsible for your missed session. This applies to first sessions as well.***

Frequency of sessions:

Should you wish regular sessions on an ongoing basis, I will offer you a date and time that will be designated your time each week. Should you wish sessions on a less frequent basis (bi-monthly or monthly) I cannot guarantee my availability but will do my best to work with your schedule.

Note regarding Insurance Reimbursement:
Due to the complexities and time delays of insurance reimbursement, **I ask that you pay for your session before or on the day of your session. You may pay using the following methods listed below.**

Fee:
The hourly fee for service covers a 50 minute session beginning promptly at the appointed time. **A 50 minute session is $240.00**. A change in the hourly rate may occur on an annual basis but any increase will be discussed with you well in advance.
Payments made be made using one of the methods below:

- **Cash (When in person)**
- **Check -** Please make the check out to: **Suzanne La Placette, Ph.D.**
- **Venmo** - please add me to your account using my name or this email address: slaplacett@mac.com. I encourage you to keep our transactions private.
- **Zelle** - My account can be found using **Email address only** - slaplacett@mac.com.
- **PayPal** (using only the family and friends setting)

Confidentiality:
All information disclosed during a session, including that of minors, is confidential and will not be disclosed to anyone without written consent.

Confidentiality does not apply under the following conditions:
- **If there is a reasonable suspicion of child abuse and/or neglect.**
- **If there is a reasonable suspicion of elder abuse and/or neglect.**
- **If you communicate to me a threat of harm toward yourself and I consider you to be a danger to yourself.**
- **If you communicate to me that you intend to harm another person(s) and I consider you to be a danger to them.**

Should any of the above conditions be met, I will contact the appropriate law enforcement agency and/or protective service agency.

Terminations:
Our therapeutic relationship is very important to me and communication between us is essential. However, in the event that I have not heard from you for 4 consecutive weeks and no prior arrangement has been agreed upon, I will consider our therapeutic agreement to be null and void. Should you wish to begin treatment again, at anytime in the future, a new informed consent will need to be signed and the current fee structure will apply.

At times I may engage in professional consultations. At such times neither your names or identifying information will be revealed.

In the event of a Medical Emergency, call 911 or go to your nearest Emergency Room.

CONSENT TO PSYCHOTHERAPY:

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

Printed Name of Patient:_____

Patient's Signature:_____

Date:_____