Deb Elkin, LPC
2307 Desmond Drive
Decatur, Ga. 30033

Informed Consent to Treatment

Welcome to my practice. Please read this carefully as it pertains important information about my professional services and business policies.

My approach to psychotherapy is based on 40 years experience working with individuals dealing with depression and anxiety, trauma and loss, relationship challenges, general life stress management, and personal and spiritual growth. I have a holistic approach to therapy, integrating body, mind and spirit into my work.

Confidentiality

No information will be disclosed about you to another party without your explicit authorization, unless required by law. The law may require disclosures in circumstances such as orders of a court, subpoenas, or where necessary to protect you or someone from imminent danger. As part of my efforts to provide the best possible care, I participate in a peer consultation group with other mental health professionals. Although I may discuss specific cases, I will keep confidential your name and other identifying information.

Payment

My fee for this service is $135 for individual sessions. Payment is expected at the time of treatment. You can pay via cash, check or credit/debit cards. I do add a small fee for payment by cards. If you need to cancel an appointment, please give me 24 hour notice or you will be charged for the session. Of course I make exceptions for unpredictable emergencies or illnesses.

Insurance Reimbursement

Clients are expected to pay at the time of service. If your insurance company reimburses for out-of network providers, I will be happy to provide you with a monthly receipt upon request.

Contacting Me

My telephone number is 404-320-9548. This is a confidential voicemail. I will generally return calls within 24 hours with the exception of weekends and holidays. Please leave your phone number even if you think that I have it and some good times to reach you. If it is an emergency and you cannot wait for me to return your call, you have several options: call a

friend or another member of your support network, call your psychiatrist or primary care physician, call or go to your nearest hospital's emergency room. If I am unavailable for an extended period of time, I will provide you with the name and number of a trusted colleague whom you can contact if necessary.

Discontinuation of Treatment
Either of us may elect to discontinue treatment at any time. It is desirable to have at least one closing sessions if a decision to discontinue treatment is made. I will be glad to provide you with referral sources if you desire.

I UNDERSTAND AND AGREE TO THESE CONDITIONS AND I CONSENT TO TREATMENT.

_____
print name

_____
signature

_____
Date