



# Emotional Wellness Therapy

*Coping effectively with life and creating satisfying relationships*

## Therapy Agreement Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

### Informed Consent for Therapy

I understand that therapy is a collaborative and supportive process aimed at improving emotional well-being. I recognize that results may vary and that personal commitment plays a crucial role in progress. I acknowledge that my therapist provides professional guidance but cannot guarantee specific outcomes.

I also understand that therapy is confidential. Information will never be shared without your written consent, except in situations where disclosure is required by law, such as:

- If there is a serious risk of harm to yourself or others.
- If child, elder, or dependent adult abuse is suspected.
- If therapy records are subpoenaed by a court.

By signing below, I confirm that I have received sufficient information about therapy and voluntarily agree to proceed with therapy under these conditions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Authorization for Services

I authorize **Cheryl Nelson, Clinical Social Worker**, to provide therapy services to me. I understand that therapy may include discussions about personal history, emotions, and behavioral patterns. I commit to participating openly and honestly in this process to support my growth and well-being.

I understand that payment for services is due at the time of each session by e-transfer unless otherwise arranged. I understand that insurance companies are not billed directly, and it is my responsibility to seek reimbursement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Cancellation & Rescheduling Policy

I acknowledge that consistency is important for therapy and commit to attending scheduled sessions. I understand that if I need to **cancel or reschedule**, I must provide at least **24 hours' notice** to avoid a late cancellation fee.

If I cancel **less than 24 hours** or fail to attend without notice, I will be charged the full session fee of **\$225.00**. I understand that exceptions may be made in emergency situations at the therapist's discretion.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_