Rawers Therapy

Informed Consent for Treatment & Office Policies

Please read the entire document carefully and be sure to ask your therapist any questions you have regarding the contents before indicating your agreement with the terms of this document. Thank you.

FEES. The fee for a single 50-minute psychotherapy session is $175. A fee reduction based on financial resource level may be considered in some cases. Payment is due at the beginning of each session in the form of personal check, cash, or major credit card.

CANCELLATIONS. There is a 24-hour cancellation policy (regardless of reason). Cancelled or missed appointments will be billed at full rate. Clients using insurance are also personally responsible for fees related to cancelled or missed appointments.

PHONE SESSIONS. Scheduled Telephonic sessions are available between office visits when planned in advance, and will be charged at the full fee rate in increments of 15 minutes. Unscheduled emergency phone services are not available.

TEXTING. For scheduling or administrative purposes, texting is welcome. Please avoid the use of texting for therapeutic or non-administrative use, and never as an emergency contact method.

SOCIAL MEDIA. Please be advised that your treatment provider, for your privacy and confidentiality, will elect not to accept any invitations to join, or participate in any social media activities that you may be engage in.

INSURANCE. It is your responsibility to understand and verify the benefits and limitations of your insurance policy. If your insurance denies payment, you agree to be responsible for any unpaid balance.

RETURNED CHECKS. A $25 fee will be added to your original balance in the event of a returned check.

CONFIDENTIALITY. All communications between you and your therapist will be held is strict confidence unless you provide written permission to release information concerning your treatment. If you are participating in couples or family therapy, then your therapist will not release information without the written permission of all persons participating in treatment.

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Please note the following mandated exceptions to client-therapist confidentiality, including:

a) Suspected Child / Elderly / Dependent Abuse
b) Instances of client presenting danger to self or others
c) Compliance with Federal Law (Patriot Act 2001)

ABOUT THERAPY. It is the intent of your therapist to provide services that will assist you in reaching your therapeutic goals. Based on the information you provide the therapist and the specifics of your situation, your therapist will provide a recommendation to you regarding treatment. Based on the idea that the client and therapist are partners in the therapy process, you have the right to agree or disagree with your therapist's recommendations. You will be offered periodic feedback regarding your progress and are encouraged to participate in the process. Due to the individuality of each case, your therapist cannot provide you with predictions of length of time required to achieve your goals. Also you agree and understand that there are some risks to participating in therapy, including but not limited to, the possibility of redefining current relationships. In the event of Couples or Family Therapy, all parties agree to the "No Secrets" policy, releasing the therapist from any obligation to withhold information learned in individual session from others in the larger treatment unit, i.e., your partner or family members.

TERMINATION. The length and the timing of the eventual termination of your treatment are dependent on the specifics of your situation and treatment plan. Your therapist will discuss a plan for termination as you approach the completion of your treatment. You may elect at any time to discontinue treatment.

CONSENT. Your signature indicates that you have read and understood this agreement and its contents.

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Printed Name	Signature	Date