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INFORMED CONSENT FOR THERAPY

Welcome! Dr. Petak understands that the decision to seek therapy is a very important one, and is honored that you have decided to work with her. She would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality, and office policies.

Financial Terms/Insurance: Payment is due at the end of the month upon receiving a bill from Dr. Petak. In addition to therapy appointments, fees may be prorated for time spent for other professional services rendered. Other services may include, but are not limited to, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, and preparation of records or treatment summaries. If you become involved in legal proceedings that require psychologist's participation, you will be expected to pay for this time, even if called to testify by another party. The fees for professional time related to legal involvement (e.g., preparation and attendance at a legal proceeding) differ from that of the therapy session fee and will be discussed at that time. If you fail to meet your financial responsibilities within 60 days and arrangements for payment have not been agreed upon, your account may be turned over to a collection agency or appropriate court. If such action is necessary, you will be responsible for any expenses incurred.

Insurance Reimbursement: Please note that Dr. Petak is an out-of-network treatment provider and does not participate on any health insurance panels. Most insurance plans offer an out-of-network benefit for mental health. Please check with your insurance carrier regarding the details of your plan. It is your responsibility to find out about your coverage (e.g., deductibles, number of covered sessions, authorization needed to begin therapy, etc.). The bill Dr. Petak provides contains all of the information needed to submit to insurance for reimbursement, but Dr. Petak will be paid directly by the responsible party.

Cancelled/Missed Appointments: A scheduled appointment means that time is reserved only for you/your child. If an appointment is missed or cancelled with less than 24 hours notice, you will be billed at your usual fee. Repeated missed appointments may result in termination from treatment.

Confidentiality: Issues discussed in therapy are generally confidential. However, there are limits to confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person, or a disabled person, 2) when your therapist believes that you/your child is in danger of harming him/herself or another person, 3) if you or your child report that you intend to physically injure someone, the law requires your therapist to inform that person as well as legal authorities, 4) if your therapist is ordered by a court to release information, 5) when your insurance company is involved (e.g., filing a claim, insurance audits, case review, etc.), 6) in natural disasters whereby protected records may become

exposed, or 7) when otherwise required by law. You will be asked to sign a Release of Information so your therapist may speak with family members or other professionals involved in your child's care.

Contacting Dr. Petak: Dr. Petak may not be immediately available by telephone. Please leave a voicemail, which is checked frequently, and your call will be returned as quickly as possible. If it is a clinical emergency, and the phone is not answered immediately, contact your family physician or go to your nearest emergency room. It is requested that you do not use email or text messaging as a mode of communication about any emergent matter but only for routine administrative manners such as scheduling.

Client Satisfaction: Dr. Petak is committed to working with you/your child to the best of her ability. Feedback about your therapy experience is welcomed. If you have any concerns at any point with the course of treatment, please do not hesitate to speak candidly about it.

Consent for Treatment: You authorize that Dr. Petak may carry out treatment and/or diagnostic procedures that now or during the course of your care are advisable. You understand that the purpose of these procedures will be explained to you upon request and subject to your agreement. You also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

I UNDERSTAND AND AGREE WITH THE ABOVE POLICY STATEMENTS AND HEREBY SIGN:

_____ _____

Name Signature

_____ _____

Name of Minor's Parent/Guardian Signature of Minor's Parent/Guardian

_____

Date