**Informed Consent for Psychotherapy and Office Procedures**

Thank you for choosing our practice to provide you and your family with therapy services. This is a brief summary of our office procedures and fees.

Please feel free to discuss any question you may have with your counselor.

**Scheduling:**

A session lasts for 45 minutes. Since you are likely to want to accomplish as much as possible in this time, we encourage you to be sensitive to time limits so that you do not run out of time when you have important issues to discuss with your therapist. If you are late for your appointment, your therapist may only be able to see you for the remaining time that has been scheduled for your appointment.

As is the case in most psychotherapy offices, we have a 24 hour cancellation policy. If you miss a session or cancel it without 24 hours notice, you are responsible for the full payment, not just your co-payment because your insurance will not pay for missed appointments. If you have to cancel a session due to an emergency, you may discuss extenuating circumstances with your therapist.

**Fees:**

We believe it is important to have a clear and complete understanding between you and therapist with regard to your financial arrangements for professional services. Therefore, your fee will be explained during your first session.

**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING**

**Medical Services Authorization Cancelled Session Responsibility**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge

the release of any medical information that I will be responsible for full

necessary to process a claim for services payment of fees for sessions

rendered. I authorize payment of cancelled with less than twenty four

medical benefits to undersigned (24) hours notice.

physicians or suppliers for rendered

services described.

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Print Name DOB Print Name

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**Signature of Patient or Date Signature of Patient or Date**

**Responsible Party Responsible Party**