

INFORMED CONSENT TO TREATMENT

CONFIDENTIALITY STATEMENT

I understand and agree to the following:

- 1 that treatment offered by Ilene English, LMFT, is voluntary in nature, unless I am under the age of 18.
- 2 that, within certain limits, information that may be revealed during therapy will be kept strictly confidential, requiring a written authorization from all parties in treatment if any information is to be released to any outside parties, with the exception of my insurance company.
- 3 that if I reveal information indicating that I may be a threat either to myself or others, my therapist may be permitted and/or mandated by law to reveal this information to other persons or agencies for the safety of myself or others. This would include instances of suspected child abuse when treating a child under 18 years of age.
- 4 FINANCIAL AGREEMENT - The fee per visit is \$125 for Individual Therapy, \$200 for Couples Work, and \$35 week for Groups, payable at the time of treatment.
- 5 FINANCIAL POLICY – You are responsible for payment of services, though you may be able to get reimbursement through your insurance. We will gladly provide you a super bill for your insurance company. You are responsible for the full fee regardless of your insurance company’s reimbursement policies.
- 6 PAYMENT IS DUE IN FULL AT THE BEGINNING OF EACH SESSION. FEES ARE SUBJECT TO CHANGE EVERY SIX MONTHS.
- 7 NO-SHOW AND CANCELLATION POLICY - Your visit has been reserved for you. 24 hours notice is required for cancellation. Otherwise you will be charged for the missed session, unless caused by serious illness or under dire circumstances.

- 8 I have read and understand this information sheet and informed consent.

SIGNATURE _____

SIGNATURE _____

PARENT'S NAME (If client under 18):

PARENT'S SIGNATURE

THERAPIST'S NAME: ILENE ENGLISH, MFT

THERAPIST'S SIGNATURE

DATE _____