

CONSENT FOR TREATMENT

Welcome to my practice. Therapy can be an extremely rewarding experience, and it is essential to understand some of the things you can expect as we begin working together. The following guidelines should help. Should you ever have any questions or concerns about the information contained in this consent, please do not hesitate to share them with me.

The experience of psychotherapy is different for every individual and depends on a variety of factors, including the particular problem, desired goal, background, experiences, etc. Talking about difficult issues can lead to painful feelings from the past and other life challenges. By being an active participant and working on the tools learned in session, your relationships and quality of life will improve, including a reduction of stress and frustrations.

CONFIDENTIALITY:

Communication between therapist and client is both privileged and confidential. I cannot discuss your case orally or in writing with anyone. Our communications will remain confidential unless you request otherwise by signing a "Release of Information." There are certain exceptions to this, which I have listed below. A psychotherapist has an ethical and legal obligation to break confidentiality under the following circumstances:

- a. If there is a reason to believe there is an occurrence of child, elder, or dependent abuse or neglect.
- b. If there is reason to believe you have a serious intent to harm yourself, someone else, or property by a violent act you may commit.
- c. If you introduce your emotional condition into a legal proceeding or I am subpoenaed to give testimony.
- d. **Consultation:** Therapists often consult colleagues to provide the best possible treatment. Your confidentiality is important, and your name or identifying information is never used.

FEES/APPOINTMENTS/CANCELLATIONS:

Individual sessions are 50 minutes (\$200), and couple sessions are 90 minutes (\$300), payable at each session unless we have made other arrangements. At times I may offer a lesser fee in order to accommodate your ability to pay. I accept credit cards, Venmo, Paypal, Zelle, cash, or checks. Please make checks payable to Tracey Harvey, PhD.

We will decide on a specific day and time for your session(s) together. I will set the time aside for you and will not give your time to anyone else. To avoid paying for missed sessions, I require 24 hours advance notice if you cannot keep your appointment. Of course, allowances will be made for illnesses, serious emergencies, and vacations. If you cannot attend a session for any other reason, I will try to reschedule you for that week.

Deciding the best course of treatment is a decision that should be made between you and me. So that an insurance company does not influence such decisions, I have chosen not to be an in-network provider for any carrier. This further protects my clinical independence and your confidentiality.

As a licensed marriage & family therapist, my services are covered under most insurance plans for which you can utilize out-of-network coverage. Should you wish to bill your insurance, I will provide you with monthly statements (“superbills”) with the necessary information to seek reimbursement. You may want to consult your insurance provider as reimbursement rates vary from plan to plan and may change based on the diagnosis. Any unpaid fees for over 60 days are subject to legal action, which may involve hiring a collection agency or going through small claims court.

CLIENT RIGHTS AND RESPONSIBILITIES:

In addition to your right to confidentiality, you have the right to end your therapy at any time, for whatever reason, without any obligations except for the fee already incurred. You also have the right to question any aspect of your treatment and expect that I will maintain professional and ethical boundaries with you, not entering into any personal, financial, or professional relationships with you which could compromise the therapeutic relationship.

Please sign this consent form for treatment, indicating that you have read, understood, and agreed to the above.

Name of client _____

Signature of client _____

Date _____

Intake Questionnaire

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Home: _____ Work: _____

Email address: _____

Do you have any current or past medical conditions? _____ No _____ If Yes, please explain:

Do you have any current or past mental health conditions? _____ No _____ If Yes, please explain:

Are you currently taking any medications? _____ No _____ If Yes, please list:

How would you rate your physical health? _____

Do you consider yourself to be spiritual or religious? _____ No _____ If Yes, please explain:

How would you rate your current sleeping patterns- On a scale of 1-5 (1 poor—5-very good) _____

List any specific sleeping problems _____

Are you currently employed? _____ No _____ If Yes, what is your current employment situation:

Do you enjoy your work? Is there anything stressful about it? _____

How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

Please list any difficulties you experience with your appetite or eating problems. _____

Are you currently experiencing any sadness or grief? _____ If so for how long? _____

How much alcohol do you drink in a week? _____

How often do you engage in recreational drug use? _____

Are you currently in a romantic relationship? If yes, for how long.

On a scale of 1-10 (1-poor and 10 being exceptional), how would you rate your relationship? _____

What significant life changes or stressful events have you experienced lately? _____

What do you consider to be some of your strengths? _____

What do you consider to be some areas of weakness? _____

What would you like to accomplish out of your time in therapy? _____

Credit Card Authorization Form

Client Name: _____

Cardholder Name: (if different than client) _____

Billing Address: _____

City _____ **ZIP** _____

Credit Card Type: _____ Visa _____ Master Card _____ AmEx _____ Discover

Credit Card Number: _____

Expiration Date: _____

Security Code (CVV, last 3 numbers on back of card) _____

I authorize Tracey E. Harvey, PhD, to charge the agreed-upon amount to my credit card provided herein. I understand that my card will be billed the day of the session, including days of missed sessions and/or cancellations, within 24 hours' notice, as explained in the Consent for Treatment. I agree to pay for this amount in accordance with the issuing bank cardholder agreement.

Cardholder Signature: _____

Date: _____