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INFORMED CONSENT AND AGREEMENT FOR PSYCHOTHERAPY

1. I place a high value on the confidentiality of the information you share with me. State law and professional ethics also require therapists to maintain confidentiality and not to release information about you without your written consent.

2. I am required by law to report any suspected child abuse or neglect. This law is designed to protect children from harm. In the event that I learn information that could result in danger, injury or harm to you to your property or to others or to their property, then I have a duty to notify the State of New York, that in my judgment would reduce that risk of danger.

3. If an insurance carrier or a managed care company is paying for your treatment, you should be aware that your treatment records are available to them upon request and that they are likely to put your treatment information into a central computer database that could be accessed by others.

4. I may have occasion to consult with professional colleagues about our work together. However, your name and other identifying information would not be revealed without your expressed consent.

5.  If I am away or unavailable, and another therapist is covering my practice, it may be necessary to share some information about our work together in order for the covering therapist to help you in an emergency situation.

6. The fee for therapeutic services or copay will be agreed upon in the first treatment session.

1. The psychotherapy session will be 50 minutes in length.

8. **If a session must be cancelled it is required that you give me two business days advanced notice in order to avoid you being billed for that time. If you give me less than two business days notice and I am unable to reschedule another client at that time you will be billed for any appointment that you do not keep or cancel**. Rescheduled appointments for the same week will be offered whenever possible.

9. Generally, there will not be a charge for short telephone conversations. However, telephone contact with you or others about your treatment, which is of significant length, may be billed. Such telephone contacts may not be covered by your health insurance. Likewise, meetings outside the office related to your treatment will be billed and if travel time is significant, it may also be billed and that too may not be covered by insurance.

10. You are making the choice to begin psychotherapy. You have the right to end your treatment at any time. If you decide to leave the treatment, you are encouraged to speak with me before leaving so we can end our work together appropriately and I can assist you with making plans for future treatment if necessary.

11. It is understood that I am engaged to provide psychotherapeutic treatment, not “expert testimony” for a court. As my client you agree not to require me to provide “expert testimony” in any litigation. Should I be subpoenaed or be required by a court to participate in a deposition, give testimony or other services, you agree to pay me for time spent at a rate equal to $250 per hour.

By signing below you indicate that you have read and understood this agreement and give consent to treatment.

Patient’s Name(s) Print \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Parent if patient is a child): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_