

*Catherine E. Rosick, M.Ed., NCC, LPC*  
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**INFORMED CONSENT FOR TREATMENT**

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask any questions that you may have during your session. Once you sign this, it will constitute a binding agreement between us.

**CONFIDENTIALITY**

Law protects the confidentiality of all counseling interactions. Unless you grant me written permission, I will neither inform anyone that you and/or your minor child/children are receiving counseling, nor will I disclose the content of any session. However, there are circumstances that impose on a client's right or ability to maintain a privileged communication. These circumstances include: medical emergencies; the existence of a threat of danger to self or others; reasonable suspicion of current physical/sexual abuse of a child or elder; abandonment or neglect; a court order; receipt of a properly executed consent form; and where otherwise legally required.

\_\_\_\_\_ **Initial**

**PROFESSIONAL FEES**

My fee for each 50-minute session is \$120.00. Clients receiving counseling are expected to pay at the time services are rendered. Payment can be made by cash, check, or charge (MasterCard, Visa, and American Express). Clients who are using insurance are responsible for any co-pays, co-insurance, and yearly deductibles. Client telephone calls, consultations with other professionals, and report preparation of less than 15 minutes are conducted without charge. Those exceeding 15 minutes are billed at the 50-minute per session rate.

\_\_\_\_\_ **Initial**

**CANCELLATIONS AND MISSED APPOINTMENTS**

I understand that, at times, it may be necessary to cancel an appointment. To help me be most effective and responsible in the use of my time, I require that any changes or cancellations be made at least 24 hours before your scheduled appointment. Because your appointment time is held exclusively for you, any cancellations received less than 24 hours before your scheduled appointment will be charged \$50.00. Insurance does not cover cancellation fees for missed appointments.

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**CLIENTS' RIGHT AND RESPONSIBILITIES**

As the client, you have received a form in this packet explaining your rights and responsibilities. After reading this form, you may ask any questions needed to fully understand your rights and responsibilities. You can address any concerns or grievances with your therapist, Catherine E. Rosick, M.Ed., NCC, LPC. You may also contact the Board of Behavioral Health, the licensing board that regulates this therapist's professional practice.

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**CONTACTING ME**

As your therapist, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by an automated voice messaging system, which I monitor seven days a week. I will make every effort to return your call within 24 hours. If you are difficult to reach, please leave the times you will be available. If your situation is an emergency, please call 911, Value Options Crisis Line at 602-222-9444, Teen Lifeline at 1-800-784-8336, or EMPACT Suicide Hotline at 480-784-1500.

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**I have reviewed the information on this page and have had questions answered to my satisfaction and therefore accept these provisions. I agree to have myself and/or my minor child/children participate in therapy.**

Client Name (Please Print) \_\_\_\_\_

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

(If client is a minor)

Date \_\_\_\_\_