**Sarah-Kate Venison, LMFT**

 **SKVenisonLLC**

 **(203) 241-9044**

**Client Information and Consent Form**

**Please read and sign at the end stating you have fully read and understand the information below**:

**Client/Therapist Relationship:** The Therapeutic relationship exists exclusively for treatment purposes. The relationship functions most effectively when it remains professional and involves only the therapeutic aspect. I can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist.

We will evaluate progress on a regular basis. Appropriate referrals for additional supports or other providers will be provided if we find this to be the best course of action. Collaboration with other professionals will be sought where appropriate and will only be contacted with your written permission.

**Confidentiality:** I follow all ethical standards prescribed by professional code of ethics (AAMFT) and state and federal law. All records are confidentiality maintained. No records will be released unless there is express written permission from you to share the records. I will not even acknowledge your participation in treatment without prior permission from you. This includes legal representatives and family members. In the rare event that records are requested for legal matters, release requires a court order. Minors are the exception, where information will be shared with parents/guardians as appropriate in order to collaborate in reaching treatment goals. I actively encourage open communication between family members.

**The Law states that there are exceptions to confidentiality. It is my responsibility to report any suspected child or elder abuse and/or neglect and to report to law enforcement any clients dangerous to themselves or others. Further, the law requires that I warn the intended victim of a crime.**

**Appointments:** Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. I request 24 hour notice for cancellation or rescheduling, otherwise you will be financially responsible for the time reserved for you. One exception per year will be extended for emergency purposes. I ask for a credit card to ensure ease of reimbursement should there be a late cancellation I check my voicemail regularly and will make every effort to return calls in a timely manner. Brief phone calls are appropriate to support therapy. Should longer phone consultations be required, my regular fees will be billed.

**Emergencies:** I will return calls as soon as possible.As appointments are booked back to back, the time may vary. Please call 9-1-1 in case of life threatening emergencies and 2-1-1 in case of psychiatric emergency. A follow up call to me is requested so that I can assist with treatment planning and discharge.

**Payment:** Payment is expected at the time of each appointment. If you are using insurance or an HSA account, a statement will be sent to you monthly so you can submit for reimbursement. A monthly statement is issued to all clients for receipt and record purposes.

 **Fee Schedule:**

Diagnostic and Evaluation Session $220

 Regular visits $195

 Extended sessions (by agreement) $275

 Outside office services (court, schools, meetings) $195/hr

 Written reports/emails (prorated to parts of hour) $195

 Less than 24 hour notice/no show $195

A reasonable fee will be charged for copies of any records requested.

**Consent to Treatment**: By signing this form, as the client or guardian of the client, I acknowledge I have read, understand and agree to the terms and conditions contained in this form. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (and/or my child if the child is the primary client). I may stop these services at any time. **NOTE:** If you are consenting to services for a minor child, and if there is any court order pertaining to conservatorship of said child, or impacting your rights with respect to consent to the child’s mental health care and treatment, I will not render services until I have a copy of the most relevant and/or the most recent applicable court order. In cases of joint custody, all parents/guardians will be contacted, asked to consent and invited to actively participate in therapy. Participation of significant caring adults in a child’s therapy is imperative.

Signature – Parent/Client Date

Signature – Spouse/Partner/Parent Date

Signature – Therapist Date

I hereby authorize the release of necessary medical information for reimbursement purposes and authorize payment of medical benefits to the provider of services.

Client/Parent (insurance carrier) Date

I ask that clients give me a charge card to keep on file. The card will be charged per session if that is our clear financial arrangement. It will only be charged otherwise in the event of not showing up for an appointment or a late cancellation. I understand that situations arise from time to time, however I ask that clients respect my time and effort on their behalf.

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_