CONSENT TO PARTICIPATE
IN THERAPY FORM

for

Psychotherapy/Consultation Services

by

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Please read this document carefully and completely. Then sign below to signify that you have read this document and accept its terms.

Terms of Psychological Care

What to Expect.
Engaging in Psychotherapy is a joint, professional relationship between you and me. My commitment to you is to provide you with the best possible care that I will individualize to meet your unique needs. You, your progress, and our working relationship will receive my fullest attention and superior personal care.

Working together with you, I can help you resolve the challenges that led you to schedule this appointment. Your decision to seek my help is the first step in what I hope will be a mutually satisfying experience for us both.

Therapy is a process that includes developing insight, discovering yourself, and problem solving. Most people seek therapy because of discomfort in one or more areas of their everyday lives, causing depression, anxiety or stress. You might experience any of the following: worries, obsessions, nervousness; frustration, anger; conflicts with family, friends or co-workers; irritability, emotionality; sleep, health, or eating problems; overwhelming stress; substance overuse/abuse; difficulties with memory, attention or concentration; troubling emotions such as fear, nervousness, anxiety, depression, anger, or frustration; and withdrawal or avoidance. These are common reasons for people to seek psychotherapy, and there can be other issues as well. My goal is to help identify the source(s) of your distress while helping uncover tools and coping strategies to address the root causes of your

situation and ultimately assist you toward making desirable change that fosters lasting growth. Before our work is complete, you may experience temporary worsening of some symptoms as you work through your issues, which is sometimes necessary in order for lasting growth to occur.

Payment is required at the time of session.
Payment is due at the time of service in the form of check, cash or credit card. If you have any difficulties making a payment, please contact me immediately with your concerns. If you encounter unexpected difficulties, or if your financial situation changes, please contact me immediately. I will work with you to make therapy as manageable as possible.

Late charges may apply for late payment, and cancellation fees may apply to appointments cancelled under 48 hours (see Cancellation Policy). If my bank returns your check, you will receive the corresponding processing fees. You will receive receipts in duplicate at the time of payment for your records and for insurance reimbursement back to you.

Cancellation Policy.
Regular attendance to therapy insures the best possible outcome for you. To help remind you the importance of honoring this commitment, and for courtesy and respect to my other patients and to me, I require forty-eight (48) hours' notice to cancel scheduled appointments. **Please contact me via telephone at least forty-eight (48) hours in advance to notify me of any cancellations**, and kindly leave a message in my voicemail if you do not reach me directly. I will contact you to schedule your next appointment, however, you may indicate some preferences for the date and time in your message. If you cancel an appointment in shorter than forty-eight (48) hours, you will be responsible for paying my full fee for that session. Keep in mind that insurance does not cover missed appointments. Of course I understand when emergencies and sudden illnesses occur; on such occasions (at my discretion) I may not charge you for the appointment. Cancellations made well in advance (more than forty-eight hours in advance) will receive no penalties or fees.

My signature below confirms that I have read, understand, and agree to this Outpatient Services Contract, including Dr. Feldman's policies regarding What to Expect, Payment is Required at the Time of Session, and Cancellation Fees for sessions cancelled in under 48 hours' notice.

___________________________________ _________________________

Signature of Patient, Parent or Guardian Date

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Relationship to Prospective Patient/Client