INFORMED CONSENT FOR PSYCHOTHERAPY

- I agree to seek therapy for me and/or my child and to actively participate in the therapy process.
- I understand that therapy sessions carry both benefits and risks. Since therapy often involves discussing unpleasant situations and aspects of your life, you may experience sadness, guilt, frustration, and other uncomfortable feelings. On the other hand, therapy can significantly reduce the amount of distress one is feeling, improve relationships, and resolve specific issues. Psychotherapy has been shown to have benefits for people who go through it; however, improvements and "cures" cannot be guaranteed for any condition due to the many variables that affect the therapy sessions.

Confidentiality and its limits:

- I understand that I have a right to strict confidentiality and that no information about my case will be released to anybody without my prior written authorization. The following is a list of situations that may lead to Melina Quintar-Moore to break that confidentiality:

(a) there is suspicion of my involvement in child, elder or disabled person abuse or neglect
(b) there is likelihood that I pose a serious and imminent danger to myself or others due to my mood and psychological condition
(c) parents of a minor receiving therapy request access to minor's record. Parents have the right to receive general information about their child's therapy sessions, but may not necessarily have access to all information, unless Melina Quintar-Moore believes the child poses a danger to him/herself or someone else
(d) Records are ordered to be released by a court order

- I understand that Melina Quintar-Moore can be reached by calling 954-592-4661 and she will endeavor to return my call as soon as possible.
- I understand that Melina Quintar-Moore is not available 24 hours a day. If in a crisis, I should call my family physician, the Henderson Crisis team at 954-463-0911, 911, or report to the emergency room at the nearest hospital.
- I have read and understand the above statements and agree to abide by its terms during my professional relationship with Melina Quintar-Moore.

_____ _____

Client Signature Date

AUTHORIZATION FOR MANAGED HEALTH CARE/EAP CLIENTS

- I am aware that insurance companies require my therapist to provide them with a clinical diagnosis after our initial meeting.
- I understand that additional information may be required for the purposes of case management, quality assurance and/or utilization review.
- Though all insurance companies claim to keep such information confidential, my therapist has no control over what they do with it once it is in their hands.
- I authorize Melina Quintar-Moore to release information necessary for her to process claims and be paid for services rendered.

_____ _____

Client Signature Date

FINANCIAL AGREEMENT AND CANCELLLATION POLICY

- I understand that payment for services is due at the time of service. Payment can be made with cash, personal check, or credit card (I will be responsible for a 4% processing fee if using any type of credit card)

- I will be contacted 24 to 48 hours prior to my appointment as a reminder of my appointment. However, it is my responsibility, not my therapist's, to keep track of my own appointments.

- I will be responsible for giving 24 hours advance notice if I am unable to keep my appointment. My therapist will try to reschedule the appointment for the same week. If unable to do so, I will be charged a $50.00 late cancellation/No Show fee. My insurance will not pay for that fee; I will be responsible for paying it prior to or at the time of our next appointment.

_____ _____

Client Signature Date