NURTURE CHILD & FAMILY THERAPY CENTER

# Informed Consent for Therapy/Consultation

## Fees and Insurance

Fees are payable at the end of each session with check, credit card or cash. There is a 2.75% fee for credit card payments. $25 will be charged for a returned check in addition to the original amount. I do not accept insurance at this time. It is your responsibility to submit claim forms to your own insurance company for out-of-network coverage. An invoice can be provided for this purpose.

## Appointment Scheduling and Cancellation Policies

If you are unable to attend your scheduled appointment, you must call **at least 24 hours in advance, or you will be charged a full session fee.** If you arrive late for a session, you will be seen for the remainder of the session, but you will be charged the full fee. If your therapist is running late, you will be either given your full 45 minute session, if the schedule permits, or be charged a pro-rated fee for a shorter session.

## Phone and Skype Sessions; Phone Calls and Other Non-Routine Services

Phone and Skype sessions are charged at the same rate as regular sessions. There is no charge for phone calls up to 10 minutes. Extended phone consultations, crisis intervention, report writing, and extended care coordination with other providers will be pro-rated based on the hourly rate.

## Confidentiality

All communications between client and therapist will be held in strict confidence, except under the following circumstances, where the therapist may be required or permitted to break confidentiality:

1. Therapist has a reasonable suspicion that client is a danger to himself/herself or someone else.
2. Therapist has a reasonable suspicion that client could cause significant damage to a property.
3. Client discloses abuse, neglect, or exploitation of a child, elderly, or disabled person.
4. Client discloses sexual contact with another mental health professional with whom client had/has a professional relationship.
5. Therapist is ordered by a court to disclose information.
6. Client directs therapist to release the client's records and sign the “Authorization for Release” form.
7. Therapist is otherwise required by law to disclose information.

This policy of the limitations of confidentiality is aligned with the ethical and legal guidelines for mental health professionals in the sate of New Jersey.

Communications between therapists and clients who are minors (under the age of 18) are confidential. The holder of the privilege is the minor. Confidentiality and limitations of confidentiality in terms of the treatment of certain topics such as substance use and sexual activity will be discussed with teens and their parents. Anytime therapist believes that the minor is in danger of hurting him/herself or others, therapist will notify parents immediately.

## Emergency

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If you have a psychiatric emergency, please call 911 or the 24-hour emergency hotline at Jersey City Medical Center at (866) 367-6023.

**Communication**

You can reach me through e-mail at meltemp@nurturechildtherapy.com, at my office number (201) 332-5297 or at my cell (201) 993-4186.

**Record Keeping**

All mental health records are filed and stored in a locked filed cabinet. Your records are kept for 7 years post termination of services. My computers are password protected.

**Termination of Therapy**

You may discontinue therapy at any time. If you or your therapist determines that your child is not benefiting from treatment, either of you may initiate a discussion of treatment alternatives that may include, among other possibilities, referral, changing treatment plan, or terminating therapy. For a child client, it is very important to have a termination session if you are to discontinue therapy. Please provide therapist with advanced notice so that a termination session can be conducted with your child.

**Parental Responsibility During Therapy Sessions**

It is the policy of Nurture Child & Family Therapy Center that parents/guardians are not to leave the premises during therapy sessions. Common reasons to remain during sessions include: parent/guardian may be asked to participate in the session, unforeseen circumstances can arise and a session may have to end early (e.g., a sick child, a disruptive child, or an emergency situation).

By signing below, I acknowledge that I have received and reviewed the Informed Consent for Therapy/Consultation provided by my therapist. I understand the specific limitations to confidentiality and agree with the terms and conditions stated above.

| Name of Parent/Guardian (if minor client) | Signature | Date |
|---|---|---|

| Name of Parent/Guardian (if minor client) | Signature | Date |
|---|---|---|

| Name of Client (if older than 17) | Signature | Date |
|---|---|---|