April Scott, LCSW
Consent to Services Agreement

This agreement is intended to provide important information to you regarding your treatment. Please read the entire consent carefully and be sure to ask me any questions that you may have regarding its contents.

Information about Your Therapist

At an appropriate time, I will discuss my background with you and provide you with information regarding my experience, education, special interests, and professional orientation. You are free to ask questions at any time about me, such as, my experience and professional orientation.

Your therapist is a:
X Licensed Clinical Social Worker

Information About This Practice

The name of this practice is: **April Scott, LCSW**
The individual therapist(s) who operate this practice is:
April Scott, L.C.S.W., LCS24156

Fees and Insurance

Individual Sessions and conjoint (marital /family) sessions are approximately 50 minutes in length. If sessions are longer, that is by my discretion, I don't usually go over time. Fees are payable at the time that services are rendered. Please inform me if you wish to utilize health insurance to pay for services. If I am a contracted provider for your insurance company, I will discuss the procedures for billing your insurance. The amount of reimbursement and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions. You should also be aware that you are responsible for verifying and understanding the limits of your insurance coverage. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you. Please discuss any questions or concerns that you may have about this with me. If for some reason you find that you are unable to continue paying for your therapy, you should inform me. I will help you to consider any options that may be available to you at that time.

Confidentiality

All communications between you and I will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. (In addition, I will not disclose information communicated privately to me by one family member, to any other family member without written permission.)

There are exceptions to confidentiality. For example, therapists are required to report instances of suspected child or elder abuse. Therapists may be required or permitted to break confidentiality when they have determined that a patient presents a serious danger of physical violence to another person or when a patient is dangerous to him or herself. All communications between you and I will be held in strict confidence unless you provide written permission to release information about your treatment.

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. **However, it is important that you know that I utilize a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, I'm permitted to use information obtained in an individual session that you may have had with me, when working with other members of your family. Please feel free to ask me about the "no secrets" policy and how it may apply to you.

INFORMED CONSENT

Minors and Confidentiality

Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, in the exercise of my professional judgment, I may discuss the treatment progress of a minor patient with the parent or caretaker.

Appointment Scheduling and Cancellation Policies

Sessions are typically scheduled to occur one time per week at the same time and day if possible. I may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hrs. in advance of your appointment. If you do not provide me with at least 24 hours notice in advance, you are responsible for payment for the missed session. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies

Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to our belief that important issues are better addressed within regularly scheduled sessions. You may leave a message for me at any time on my confidential voicemail. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Client or insurance will be billed for calls over 15 minutes. If you have an urgent need to speak with me, please indicate that fact in your message, and provide sufficient information so that I have an understanding of the nature of your call. I'm only available from 8:00 a.m.-10:00pm, other hours at night, I can't guarantee a response, unless you inform me that you need extra time, or leave a voicemail. Please give me sufficient time and notice if there is a crisis, and I will make myself available. Sometimes on the weekends, I may be away from my phone, I will get back to you as soon as possible.

If your call is an emergency, to insure the safety of yourself and others, please call 911.

Therapist Communications

I may need to communicate with you by telephone, mail, or other means. Let me know if there are restrictions to communication.

INFORMED CONSENT

I have read the above information and consent to receive services from April Scott, L.C.S.W.

About the Therapy Process

It is my intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. You need to participate in the fullest degree, please don't come to session using substances, as I will ask you to leave. I believe that therapists and patients are partners in the therapeutic process. Please be prepared for some discomfort. Change is difficult, and there are sometimes effects that were not originally intended. In attempting to resolve conflicts between family members, or partners, unwanted events can occur.

Termination of Therapy

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral to another therapist, changing your treatment plan, or terminating your therapy. Your signature indicates that you have read this agreement for services carefully and understand its contents. Please ask me to address any questions or concerns that you have about this information before you sign!

Client/Parent Signature_____
Date_____

Client/Parent Signature_____
Date_____

Client/Parent Signature_____
Date_____

Therapist

Signature_____Date_____