Consent for Treatment

You have taken a very important and positive step in seeking counseling. I value our relationship and respect your dignity and your right to make your own choices. The following information is provided so that you may have full knowledge of the therapeutic services being offered to you and/or your family.

Confidentiality. Your therapy is protected health information, which is a private matter and will be treated confidentially. Any health information that can lead to your identity is considered Protected Health Information. Your Protected Health Information is governed by certain limits of confidentiality. Confidentiality must be broken under two conditions.

1.) Any information regarding new or previously-unreported child abuse, abuse of an elderly person, or abuse of a disabled person must be reported to the appropriate agency.
2.) Information that you or family member is in danger of inflicting serious harm to self or others (such as suicide or homicide) requires me to take protective measures. You will be provided a copy of the Privacy Practices that explains the ways that private information may be shared.

Emergencies. When I am not available at the office, you may leave a confidential voicemail message on my business phone at 352.448.8195. Typically, I return calls within 24 hours. If the situation is urgent and occurs after hours you may contact the Alachua County Crisis Center at 352.264.6789 or Meridian Behavioral Healthcare, Inc. at 352.374.5600. Both of these organizations operate a 24-hour, crisis response system with trained staff.

Appointments. When you schedule an appointment, that time is reserved for you and/or your family. In the event that you are not able to keep that appointment I would appreciate knowing as soon as possible. This way, another family in need may be able to use that appointment time. Please be aware that you will be billed the full fee for appointments that are not cancelled 24 hours in advance.

Fees. The fee for an initial session is $150. Each additional session is $150. I am able to assist you with filing a claim with your insurance company. It is your responsibility to obtain pre-authorization if your insurance company requires this prior to the initial session.

Accountability. I am committed to providing excellent therapeutic services to you and/or your family. Please let me know how I am doing. If at any time you are unsatisfied with the care that you or your family receives, please let me know.

Informed Consent. By signing this letter on the line below you are acknowledging that you have read and agree with this information. Your signature means that you are voluntarily requesting therapy for yourself and/or other family members. Your signature means that I have your permission to meet for therapy sessions with you and/or your family. Records of your therapy are the property of Amanda Lawson-Ross, PhD. These records may be reviewed by you at any time or may be released to others with your written permission.

CONSENT FOR TREATMENT AND HEALTHCARE OPERATIONS

I, _____, consent to the use or disclosure of my protected health information by Amanda Lawson-Ross, Ph.D. for the purpose of therapy for myself and my family members _____.

I understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of your protected health information that will occur in my treatment or in the performance of health care operations.

By my signature below, I also certify that I have been apprised of the policies described above and have been given a copy of the Notice of Privacy Practices.

_____

Client Date

_____

Parent/Guardian/Caregiver Date

_____

Family Member Date

_____

Family Member Date

_____

Family Member Date