626.888.1112
314.472.3411
ecihelp@e-motionlahcnage.com
www.e-motionalchange.com

Emotional Change Inc.

Welcome to Emotional Change Inc. I am happy that you have chosen me for therapy. I hope that you will be able to explore and implement the changes you seek. Please read the information below and be sure to ask your therapist for any clarification.

Confidentiality
All information disclosed within sessions or consultations is held strictly confidential and may not be revealed to anyone without a written release of information, except where disclosure is permitted or required by law. Disclosure is required in the following circumstances:
1. When there is a reasonable suspicion of child abuse or neglect, or abuse to a dependent or elder adult,
2. When the patient presents an imminent danger to self,
3. When the patient presents an imminent danger to others,
4. If a judge determines that our discussions are not confidential, a judge may request specific information.

If the patient is a minor, you acknowledge that your child's records are confidential except in the above stated exceptions. Please be aware that submitting mental health claims to your insurance company carries a certain amount of risk to confidentiality, privacy, and to future capacity to obtain health or life insurance, or even a job. I receive regular professional consultation. In such cases, neither your name, nor any identifying information about you is revealed.

Phone & Emergency Contact
If you need to contact me by phone, do not hesitate to call the office number. If I am not available, you can leave a message with a staff member or on the voice mail. In urgent situations, you may call me on my phone number at _____. You will be charged for phone calls if we have a conversation of an information exchanging or problem-solving nature that lasts more than 10 minutes. If you cannot reach me in an emergency, you should call 911 or go to the nearest emergency facility.

Therapy Process & Termination
Therapy can result in a number of benefits to you, including improved relationships and a reduction in psychological symptoms. The process of talking about painful memories, thoughts, and feelings, however, can be difficult and can make patients feel worse for a time. Please discuss this with me if you are feeling worse. You are free to terminate therapy at any time. I can provide you with referrals to other therapists at your request or you may call the office for a referral. I do not prescribe medication or make recommendations about medication but will refer you to your physician or to a psychiatrist if I believe you need an evaluation for medication.

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Fees & Insurance

Sessions are 55 minutes in length. Your fee is due at the beginning of the session. Please be aware that not all issues/problems/conditions dealt with in therapy are covered by insurance. It is your responsibility to verify the specifics of your coverage. Letter writing, consultations with other professionals, telephone conversations, reading records or reports, travel time, longer sessions, etc. may not be covered by insurance payment. In the event that insurance does not cover your services, you are responsible for payment. Returned checks are subject to a $35 fee. This agreement supersedes all previously agreed to financial agreements and is effective as of the date signed. You are responsible for the full copayment, deductible or private pay fee at the beginning of each session. If your account is overdue (unpaid) and there is no written agreement on a payment plan, you cannot be scheduled another appointment until it is cleared. In addition, I can use legal or other means (court, collection agencies, etc.) to obtain payment.

By signing here, you acknowledge that you have received a copy of the "Notice of Privacy Practices", the "Patients' Rights and Responsibilities" and that you understand the fee's that will be charged in the case of a missed appointment.

_____ _____

Patient/Legal Representative Signature Date

Consent for Treatment

I consent to assessment, treatment, and/or diagnostic procedures for myself or for my family member. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I authorize the release and exchange of information between my therapist and the referral source and other co-treating providers for the purpose of treatment, payment, and Health Care Operations. I also authorize the release of information to my health plan for claims or other health plan purposes.

_____ _____

Patient/Legal Representative Signature Date