Name (First, MI, Last):_____ Date of Birth: _____

Name (First, MI, Last):_____ Date of Birth: _____

Name (First, MI, Last):_____ Date of Birth: _____

Address: _____

City, State, Zip: _____

(____)_____ (____)_____

Phone Number Cell Number

Which phone number is best to contact you at and/or leave a message at? _____

Email Address: _____

Okay to use this email for Telehealth links? _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

How did you hear about my services? _____

If there is a referring person or agency, may I have your permission to thank them? _____

Informed Consent for Psychotherapy

GENERAL INFORMATION:
The therapeutic relationship is unique in that it is a highly personal, and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information, and agree to it by signing at the end of this part of the document.

THE THERAPEUTIC PROCESS:
You have taken a positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. But I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

CONFIDENTIALITY:

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests, in writing, to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens, or attempts to commit suicide, or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client, or other named victim, is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above, in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items 3 and 4 above.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name or other identifying information.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

ABOUT THE THERAPIST:
Robin N. Heffernan, MS, LMFT, LCPC has earned a Bachelor of Science in Family and Individual Development and a Master of Science with Specialization in Marriage and Family Therapy from Northern Illinois University. She is licensed by the State of Illinois as a Licensed Marriage and Family Therapist and a Licensed Clinical Professional Counselor. She has over 20 years of clinical experience in treating adolescents, adults, couples and families using various styles of therapy to assist the individual, couple or family in meeting their intended treatment goals.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature(s) _____ Date: _____

Financial/Insurance Responsibilities

Name of the person who has the insurance policy: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Company Name: _____

Plan Name: _____

ID #:_____

Group #:_____

EAP Information (if applicable):_____

As a courtesy I will bill your insurance company, responsible party or third-party payer for you, if you wish. I ask that at each session, you pay your co-payment (once known). In the event you have not met your deductible, the full fee is due at time of session until the deductible is satisfied with your insurance provider. If your insurance company denies payment, does not cover services or requests a payback due to error or change in your coverage, you are required to pay what is unpaid. If your balance exceeds $200.00, services will be suspended until a payment plan is agreed upon and balance is less that agreed amount. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Robin N. Heffernan, MS, LMFT, LCPC of Marriage and Family Solutions LLC.

COST OF SESSIONS:

Initial Session: $150.00

Individual, Couple or Family Therapy: $140.00

Bounced Checks: $15.00

Credit Card Fees: $2.00 when paid in person and $3 when paid on phone or telehealth

In the event insurance is not being used for services a separate form called a Good Faith Estimate will be required and will be renewed at the start of every calendar year.

APPOINTMENTS AND CANCELLATIONS:
Please remember to cancel or reschedule 24 hours in advance. You will be responsible for the entire fee of session if cancellation is less than 24 hours. The same fee applies in the event you fail to show for a scheduled session. Insurance companies do not pay for late cancellations or failed sessions. Cancellations and re-scheduled sessions will be subject to a full charge if **NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE.** This is necessary because a time commitment is made to you, and is held exclusively for you. If you are late for a session, you may lose some of that session time.

TELEPHONE ACCESSIBILITY:
If you need to contact me between sessions, please leave a message on my voicemail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that face-to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions or telehealth sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION:
Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION:
I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. I do not program clients' phone numbers in my phone, so please include your name in the text. In the event you don't identify yourself, please expect that my initial response to your text will be asking you to identify yourself. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature(s) _____ Date_____

Coordination of Treatment

It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent, no information will be shared.

_____You may inform my physician(s) _____I decline to inform my physician

Physician Name: _____

Clinic/Hospital: _____

Address: _____

Phone/Fax: _____

Signature(s) _____ Date_____