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INFORMED CONSENT: PRIVATE PRACTICE

I, (**myself or parents if minor**) ____
voluntarily consent to services provided by Ann W. Hines, Licensed Marriage and Family Therapist #MFC 20813, for **(myself or my child/children)** __________________________

These services may include individual, couple, child and family therapy or parent consultation. I understand that psychotherapists do not guarantee particular outcomes. I am seeking these services on my own accord and am free to discontinue at any time. I understand my therapist's training, credentials, and experience as well as the nature of the therapeutic process.

Each therapy hour is 50 minutes long. I will try to be on time for my session so that I can receive the full 50 minutes of therapy. If I am late, my session will last only as long as my original appointment schedule. My appointment schedule will not run over into another client's time.

I understand and agree to the following terms:

CONFIDENTIALITY will be maintained and information will be released only to qualified professionals and only with my explicit written permission, except in certain situations where maintaining confidentiality would result in clear and imminent danger to myself or others, or as otherwise provided by state law. The therapist is required by law to report to the appropriate authorities any suspected child abuse, elder abuse or abuse of people with disabilities. When a threat of bodily harm to me or to others is present, the therapist may break the confidentiality of our communications. If I would like my therapist to consult with my physician, previous therapist, attorney or another person who is important in my life, I will print and bring in a **"Release and Exchange of Information" form**.

Please note that if we are working in a Therapeutic Visitation, Reunification Therapy or Collaborative Practice Coaching capacity, that this is not a privileged relationship. Coaches are not in the role of "therapist" and do not have confidential relationships with their clients. I understand confidentiality and its exceptions as explained in this form.

Therapeutic supervised visitation and re-unification therapy require brief verbal reports in response to judge or mediator requests for information on how the process is proceeding. Parents will need to sign a release of information for family court before we begin.

CUSTODY: If a parent claims to have sole legal custody of a minor client, court orders will be provided for the therapist. **With joint legal custody, both parents must sign the consent to treat below before treatment begins.**

FEE: I understand that the $130 fee for a 50-minute session is due at the time of service. Checks, credit, debit and HSA medical savings account cards may be used for payment.
I will receive an insurance claim form and statement to submit for my own insurance reimbursement. I understand that Ann W. Hines, LMFT is not contracted with insurance companies, and I must call my own insurance company to to inquire about their reimbursement policy for out-of-network providers. **Telephone and cumulative email time will be billed at the usual hourly rate or portions thereof.** I am aware that any professional time spent consulting on my case, responding to phone calls or emails, or driving to appointments outside of the office will be charged to my account.

CANCELLATIONS: I understand that I am responsible for the full contracted fee for no-shows and for sessions that have been canceled without 24-hour notice. **I have asked any questions that I need to ask to understand this form in its entirety.**

Signed: ___________________________ ________________________________
Mother/ Legal Guardian for child Father/Legal Guardian for child

Over 18: Self_______________________Date: _________________________