Valerie Andersen, Psy.D.
Valerie Andersen, Licensed Psychologist PY9730

Client's Rights and Responsibilities, Professional Fees, and Consent for Treatment

IMPORTANT: *Please read carefully and initial or sign where indicated*

CLIENT'S RIGHTS

As a client, you have the right to receive available services individualized to your specific needs and provided in the least restrictive manner. You have the right to seek information about and to approve of therapeutic practices. You also have the right, at any time and for any reason, to decide you do not wish to continue counseling. With limited exceptions, information discussed is confidential. You will be asked to provide written consent if information is to be released to third parties.

The exceptions to this written consent and strict maintenance of confidentiality include:

1) Imminent physical danger to self or others
2) Suspected child / elder abuse
3) Information legitimately ordered by a court of law
4) Information required by your insurance company to process claims.

PLEASE INITIAL: _____

It is important for you to know that engaging in psychotherapy has potential emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is very helpful.

PLEASE INITIAL: _____

I am away from the office a few times a year for short vacations. I will tell you well in advance of any absences. If you are experiencing an emergency when I am out of town, or outside of my regular office hours (after 7 pm weekdays or over the weekend), you can call The ***Crisis Center of Tampa Bay*** at ***2-1-1***. In emergency situations you can also go to your ***local emergency room*** and ask for the Psychologist or Psychiatrist on call, or you can call ***9-1-1***. If you call my office number when I am out of town, outside of my regular office hours, or over the weekend, I cannot guarantee I will be able to get back to you until I return to work.

PLEASE INITIAL: _____

APPOINTMENTS AND CANCELLATIONS

Appointments can be scheduled as my time becomes available. Sessions last for 55 minutes unless we agree otherwise. If you are late, we will end on time and not run over into the next person's session. **If you miss a session without canceling, or cancel with less than 24 hours notice, you must pay for that session in full and in accordance with my cash-pay rate.** My voicemail, email and text messages record the time and date of messages, which will keep track of the time of cancellation.

PLEASE INITIAL: _____

PROFESSIONAL FEES AND INSURANCE

You are responsible for the fees that you incur with Dr. Valerie Andersen, PSYD., and not your insurance company or other third party. Parents/guardians are responsible for payment of a minor. If you fail to pay on your account, I reserve the right to turn your account over to a collection agency or attorney for collection. **If this account is assigned to an outside collection agency, an additional fee of 20% of the total amount owed will be added.**

PLEASE INITIAL: _____

PAYMENT DUE AND MEDICAL RECORD REQUESTS

Payment is due in full at the time of service. Payments may be made in cash, check, or credit card. **There is a $35.00 charge for declined credit card transactions due to insufficient funds.**

My cash-pay fee for the first session and ongoing sessions is $175/ hr (standard duration 55 minutes), unless otherwise agreed upon. If we decide to meet for a longer session, you will be billed prorated, rounded to the next quarter hour, and in accordance to the appropriate session fee (Example: $45 for 15 minutes of individual/couples counseling). Initial 20-minute phone consultations and emergency phone calls/text messages of less than 10 minutes are normally free. However, if we spend more than 10 minutes in a week on the phone/text, if you leave more than 10 minutes worth of phone messages/texts in a week, you will be billed on a prorated basis (rounded to the next 15 minutes) for that time. **If you are using insurance to cover therapy services, your insurance company will be billed and you will be responsible for any co-pays that are required by your individual plan **prior to** services being rendered.**

Requests for medical records, by insurance companies or otherwise, will not accept a claim for services without a mental health diagnosis. Like any medical diagnosis, your mental health diagnosis and treatment will become a permanent part of your medical records. If you have concerns about your confidentiality or how this might affect you, please consult with your therapist.

PLEASE INITIAL: _____

CONSENT FOR TREATMENT

I have read the above statement of "RIGHTS AND RESPONSIBILITIES AND PROFESSIONAL FEES" for Valerie Andersen, Psy.D. I understand its contents and conditions, give my consent to such, and agree to be bound by them. I, the undersigned, have voluntarily sought and agree to participate in counseling and/or psychotherapy services.

Please indicate your understanding and acknowledgement of the preceding information by signing below:

Client's Name: _____ Signature: _____

Witness: _____ Date: _____

Consent for Treatment when Client is an Unemancipated Minor

I hereby certify that I am the parent/guardian of the below named client, who is under 18 years of age, and consent to the terms of this 'Informed Consent' form for the client. (Note: If parents are divorced, the form must be signed by the custodial parent or, in the case of joint custody, by one parent. Custodial parents and legal guardians must provide photocopies of legal letters of guardianship or custody order.)

Client's Name: _____N/A_____ Date of Birth: _____

(mm/dd/yy) Parent/Guardian's Name: _____N/A_____ Relationship with

Minor: _____ Parent / Guardian Signature: _____ Date:

_____ (mm/dd/yy)