INFORMED CONSENT CONTRACT

Welcome.

I am governed by various laws and regulations and by the code of ethics of my profession. I am required to inform you about specific office policies and how these procedures may affect you.

CLIENT'S RIGHTS: Our relationship is strictly voluntary and you are free to discontinue psychotherapy at any time.

LIMITS OF CONFIDENTIALITY: Therapy sessions are strictly confidential except under certain legally defined situations involving self-harm or harm to another, and cases of child abuse, elder abuse or abuse of otherwise dependent individuals. In the case of self-harm, I am ethically bound to inform those in a position to help, or to otherwise enlist methods to prevent self-harm or suicide. In the case of danger to others, I am required by law to notify the police and to inform any intended victim(s). In instances of child abuse, elder abuse, or dependent abuse, I must notify the appropriate social service agencies. Other situations that require me by law to reveal information about you to others include a legitimate subpoena by a court of law or if you are being treated by court order.

PROFESSIONAL FEES: My fee is $175.00 per session. Payment for a session is due at the time of that session. Fees will be increased once yearly.

CANCELLATION POLICY: If you need to cancel or reschedule an appointment, please notify me as soon as possible. You will be charged for any missed sessions that are not canceled or rescheduled at least 24 hours in advance. This is necessary because a professional time commitment is set aside and held exclusively for you.

CONTACTING ME: I will return calls as soon as possible should you need to speak with me between sessions. I will make every effort to return your call on the same day it was received, with the exception of weekends and holidays. In case of an immediate emergency, if you cannot reach me and feel that you cannot wait for me to return your call, please call 911 or the nearest emergency room. In the event of a lengthy telephone session, you will be charged the hourly session fee. If I will be unavailable for an extended amount of time, I will provide you with the name of a colleague to contact if necessary.

If you have any questions regarding the above or any other questions or concerns, please feel free to mention them to me.

I HAVE READ, UNDERSTOOD AND AGREED TO THE CONDITIONS STATED ABOVE.

_____
Client Name

_____ _____
Client Signature Date

INFORMATION FORM

Date_____

Name_____ Date of Birth_____

Address: _____

_____

_____

Telephone: Home_____ Work_____

Other_____

Would it be acceptable to give my name and reason for calling if I were to leave you a message? Yes_____ No_____

Individual to Contact in Case of Emergeny:

Name_____ Relationship_____

Telephone Number(s)_____

Address_____

_____

MEDICAL PROBLEMS

MEDICATIONS PAST/PRESENT

PLEASE CIRCLE THE LEVEL OF SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:

	None	Mild	Moderate	Severe
Sadness or Depression	0	1	2	3
Suicidal Thoughts	0	1	2	3
Sleep Problems	0	1	2	3
Change in Appetite	0	1	2	3
Weight Change	0	1	2	3
Inability to Concentrate	0	1	2	3
Obsessive Thoughts	0	1	2	3
Tension/Anxiety	0	1	2	3
Memory Problems	0	1	2	3
Compulsive Behavior	0	1	2	3
Feelings of Hostility	0	1	2	3
Acts of Violence	0	1	2	3
Social Isolation	0	1	2	3
Strange Thoughts	0	1	2	3
Sexual Problems	0	1	2	3
Panic Attacks	0	1	2	3

SUBSTANCE USE ASSESSMENT (Please Circle):

Alcohol Use	Never	1-4 per month	2-3 per week	Daily
Level of Consumption	None	1-2 per sitting	3-4 per sitting	5+ per sitting
Substances Used	None	Marijuana	Sedatives	Stimulants Cocaine
	Methamphetamine	Hallucinogens	Heroin	
Frequency of Use	Never	1-4 per month	2-3 per week	Daily

HIPPA Privacy

Matt Casper, MFT: I have been and always will be totally committed to maintaining your confidentiality. I will only release information about you in accordance with HIPPA policies, state and local laws.

Treatment: Your mental health information may be disclosed to other health care professionals for the purpose of providing treatment.

My duties as your therapist: I am required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. I am also required to abide by the privacy policies and practices that are outlined in this

notice.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Law Enforcement: In the event of reported violence or life threatening dangers your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Other uses and disclosures that require your authorization: Disclosure of your mental health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you must submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual rights: You have certain rights under the federal privacy standards.These rights include but are not limited to:
The right to request restrictions on the use and disclosure of your protected health information.
The right to receive confidential communications concerning your medical condition and treatment.
The right to inspect and copy your protected health information.
The right to amend or submit corrections to your protected health information.
The right to receive an accounting of how and to whom your protected health information has been disclosed.
The right to receive a printed copy of this notice.

Request to inspect protected health information: You may generally inspect or copy the protected health information that I maintain. As permitted by federal regulation, I require that requests to inspect or copy protected health information be submitted in writing. Your request may or may not be granted, depending upon the reasoning for disclosure and what I think is best for treatment.

Signature Name