September Counseling and Wellness, PLLC
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CONSENT FOR TREATMENT

Therapy is a process that involves your active participation. It often involves resolving issues, problem solving and obtaining personal goals that will help you create a more fulfilling life. It is also common to experience changes, some of which may have both benefits and risks and can affect how you relate with others. Sometimes this process may make you feel worse before you begin to feel better. It is important that you let me know when you are having a difficult time managing these feelings. **It is also important that you agree to contact 911 or go to your nearest emergency room/crisis center should you feel you are in crisis.**

Notice of Privacy Practices

My signature below indicates that I have received a *Notice of Privacy Practices (HIPAA).*

Confidentiality Statement

Your right to privacy is protected under the law and ethics of psychotherapy. Information about you will not be released without your prior written permission (*Release of Information Form*), with the following exceptions:

1. Suspicion of child, dependent adult or elderly abuse, or neglect.
2. Reasonable belief that you are a danger to yourself or others
3. For authorization of your benefits, your insurance company requires information on your diagnosis and possibly therapy goals and treatment.
4. Certain court proceedings in which I may be subpoenaed. You agree to consult with your attorney if you are involved in a court action regarding how this might affect your confidentiality. This would include communication relevant to an issue of breach, by myself or you as the client, of a duty arising out of the psychotherapist-client relationship

Permission for Treatment of Minor

I, ____ give permission for Robin J. Sackmann, LPC,

to see my son/daughter, ____ ,

for treatment of therapy/counseling. I am the parent/legal guardian. (Please provide proof of legal custody in divorce proceedings).

This authorization is effective immediately and will remain in effect unless revoked by the undersigned at any time.

Fees
My standard fee is $150 per individual 50-55 minute session. I do offer reduced fees when available to those clients that are limited financially. If applicable, I will offer referrals to other professionals with more affordable rates so that your counseling needs may be met. I will also accept brief phone calls between sessions at no charge (up to 15”). Anything after 15” will need to be charged in 15” increments.

*Please note: I do not encourage texts as a form of communication in consideration of confidentiality. I will accept brief emails regarding appointment times only.

Agreed fee: ___________________

Cancellations
I require a 24 hour cancellation notice, otherwise you will be charged for the session *(see Cancellation/No Show Policy Form*). If you need to cancel, please call my business phone and leave a message which includes your reason to cancel.

I agree I am responsible for payment of services not covered by insurance. I understand the above conditions and hereby request psychotherapy services.

________________________________	________________________________
Signature of Client Date	Robin J. Sackmann, LPC Date

________________________________	________________________________
Signature of Client Date *or* Parent/Legal Guardian	Signature of Client Date *or* Parent/Legal Guardian