



RAVENSWOOD THERAPY GROUP

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CLIENT/THERAPIST AGREEMENT

Name: _____ Date: _____ D.O.B. _____
Address: _____ City: _____ Zip: _____
Phone: Home _____ Work: _____ Cell: _____
Who is insured? _____ Relationship to you? _____
Insurance: _____ ID#: _____ Group#: _____
Are you on any medications? _____ If so, which ones? _____
Emergency Contact: _____ Relationship to you: _____
Address: _____ Phone: _____

SERVICES: Therapist agrees to provide psychotherapy services to the client. These services may include individual, couple, or family therapy as well as any other services that are recommended by therapist. Any recommendations for treatment will thoroughly be discussed with the client.

CONFIDENTIALITY: All information concerning a client is considered confidential. Information will be released through procedures which are consistent with the law and professional ethics. Records may only be released with client's signed consent or by court order. In accordance with state law therapist is not bound by confidentiality in the event that the client threatens to harm him/herself or any other person or in cases of possible child abuse or neglect. In that instance the requirement to help or warn takes precedence over confidentiality.

FEES: Client agrees to pay therapist for services at the time of service (unless another arrangement is made between client and therapist). Fees are subject to change, however a client will be given a two month notice.

CANCELLATION POLICY: 24 hours notice is required when canceling or changing an appointment. Without 24 hours notice, client will be responsible to pay for session. This means that client will be responsible for the full amount of the agreed upon fee or, client's insurance company's "allowed amount," as a missed session cannot be billed to the insurance company.

EMERGENCIES: If a client needs to talk to a therapist immediately, client must ensure that his/her message indicates such urgency. Client will be contacted as soon as possible. However, in case of life threatening emergencies, client must call 911 or his/her local emergency number.

CLIENT CONSENT: I have read this document and agree to the terms stated.

Date: _____ Signature(s): _____

Therapist Signature: _____