CRISIS CARE: I verify, by my signature below, that I understand my counselor does not provide crisis counseling and my counseling is limited to my scheduled appointments only. In case of life threatening emergency I will call 911. Messages can be left by phone/email and my counselor will respond within 24-48 hours except during weekends, holidays or as otherwise specified. A hotline list will be provided.

_____Client Initial

PAYMENT FOR SERVICES: Clients for services at the time they are rendered. Payments can be made by check (written out to Traci Medeiros-Bagan), cash (in correct change), or major credit card.

_____Client Initial

INSURANCE REIMBURSEMENT: This provider does not take insurance or bill insurance directly. However, the therapist will discuss diagnosis and provide an invoice for reimbursement at the client's request.

_____Client Initial

FORENSIC/LEGAL PROCEEDINGS: This provider is not a specialist in forensic or legal proceedings and does not offer this type of courtroom or legal support.

_____Client Initial

CANCELLATIONS: A minimum of 24 hours notice is required for rescheduling or cancellation of your appointment. The full fee will be charged for missed sessions without notification.

_____Client Initial

CONFIDENTIALITY: All information disclosed within sessions and in the client's records is confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. Disclosure may be required under the following circumstances: Where there is suspicion of child abuse, elder abuse, adult dependent abuse, or if you're thought to be a harm to yourself or others. Disclosure may also be required pursuant to a legal proceeding.

_____Client Initial

CONSENT FOR TREATMENT: I understand that psychotherapeutic services are to help facilitate self-exploration and growth. Psychotherapy services provided are not medical advice, treatment is not time limited, outcomes are dependent on compliance with treatment, and will, also, vary by individual.

_____Client Initial

BY SIGNING THIS FORM I AGREE TO THE ABOVE AND CONSENT TO TREATMENT		
Client Name Printed	Client Signature	Date
Therapist Name Printed	Client Signature	Date