Michele Robison, PhD

INFORMED CONSENT FOR TREATMENT

I, _____, authorize and request that my (or my child's) therapist, Dr. Michele Robison, provide psychological examinations, assessment, interventions and/or diagnostic procedures that now or during the course of my or my child's care as a patient are advisable. The frequency and type of assessment will be decided between my therapist and me. I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that my child or I will benefit from this assessment and/or interventions but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- **When there is a reasonable suspicion of abuse to a child, dependent or elder adult.**
- **When the client or credible third person communicates a serious threat of bodily injury to others.**
- **When the therapist has a reasonable belief that the client may be a danger to him or herself, others or the property of others.**
- **When disclosure is otherwise required by law.**

I receive regular professional consultation. In such cases, neither your name nor any identifying information about you is revealed.

EMERGENCY TREATMENT: If you have a life-threatening emergency please call 911. I am not able to provide 24-hour availability. I usually return calls within 24 hours or the next business day. When I am out of town or otherwise unavailable, a qualified professional will be on call for me. I will provide you with that providers name and contact information prior to my unavailability or as soon as I possibly can.

PAYMENT: Payment is due at the end of each session unless other arrangements are made. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payment. My fee is $_____ per 50-minute session. I reserve the right to periodically adjust this fee.

CANCELLED/MISSED APPOINTMENTS: A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than twenty-four (24) hours' notice, you will be billed for the full amount of the missed session. Dr. Robison understands there may be times when 24 hours notice is not possible. In such cases, you must make every effort to cancel the appointment as soon as possible. It is up to Dr. Robison's discretion to waive the cancelling fee in these events.

DELINQUENT ACCOUNTS: If your account becomes delinquent (past 30 days) our office may begin collection procedures. We will attempt to contact you directly. However, if your account remains delinquent we may utilize the services of an outside collection agency, we may retain an attorney, or small claims court action may be taken.

LITIGATION CHARGES: If I am required to attend a deposition, hearing or other legal proceeding in the capacity of your current or past therapist, you will be billed at $275.00 per hour for my time, including

preparation and travel time as well as the time I spend at the legal proceeding. If you are a current or past client, my testimony will not include any forensic opinions.

TELEPHONE CONTACT: Telephone calls exceeding 10 minutes will be billed on a pro rated basis based on your 50-minute session fee. At your request and with your written authorization, I may communicate with people other than you. If any of these calls exceed 10 minutes, you will be billed on a pro rated basis based on your 50-minute session fee.

E-MAIL or TEXTING: Please be advised that I do not conduct therapy via e-mail or text messaging. You may choose to schedule or re-schedule appointments through these means or leave brief text messages or e-mails if there is something you want me to be aware of. Please note, I will respond with one or two words only to let you know I received your text or e-mail.

TERMINATION OF THERAPY SERVICES:
I may terminate therapy services at my discretion. I may consider termination if:

- **I do not believe that I can provide you with effective treatment**
- **Your needs are outside the scope of my experience or training**
- **You desire to terminate treatment or we mutually agree it is time to terminate treatment**
- **You fail to comply with my treatment recommendations**
- **A conflict of interest develops**
- **You fail to pay my fee on a timely basis**
- **You or I believe it is in your best interest**

If either you or I decide to terminate therapy services, I will recommend at least one closure session.

ADDRESS CHANGES: Please advise me if you change your address, telephone number or place of employment.

ACKNOWLEDGEMENT AND AGREEMENT FOR INFORMED CONSENT: I have read and fully understand this Consent for Treatment form.

_____	_____	_____
Client/Parent/Guardian Name	**Client/Parent/Guardian Signature**	**Date**