

Policy for Therapy Appointments

Confidentiality: All information disclosed with sessions is confidential and will not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required where there is reasonable suspicion of child or elder abuse or where there is reasonable suspicion that the client is likely to harm him/herself or others unless protective measures are taken or when required by the courts pursuant to a legal proceeding.

Contacting Me: If you need to contact me between appointments, you can call, text or email. I attempt to return each message within 12 hours during the week and 24 hours on weekends and holidays. Texts and emails are not secure and will not be used for therapeutic help. They are for scheduling, rescheduling or setting up a time for a phone call.

Emergency Procedure: If an emergency situation arises and you are unable to contact myself, call 911 and/or proceed to the nearest emergency room or clinic.

Payment: Payment is due at the time of service. You will be given a receipt to submit to your insurance. Insurance companies do require a diagnosis on the receipt. I am an out-of-network provider.

Cancellation: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for rescheduling or canceling an appointment. Otherwise, you will be charged the full fee.

I have read and understood these office policies

Signature of Responsible Party

Date

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If you are the client:

I give full consent for myself for an evaluation and/or therapy until I notify Sue Watkins LMFT of any changes or until she determines treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself.

Signature of Client

Date

If your child is the patient:

I give full consent for my child _____, for an evaluation and/or therapy until I notify Sue Watkins LMFT of any changes or until she determines treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for my child.

Signature of Parent or Guardian

Date

Privacy Policy: I have read and understood the HIPPA Privacy Policy. I understand that I can review the Privacy Policy at any time.

Signature of Responsible Party

Date