

**Cynthia Weston, MS, LMFT 42043**  
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## **Consent for Treatment**

- 1. SCHEDULED SESSIONS:** Our time together is 50 minutes for individual sessions and 90 minutes for group sessions. Telephone sessions are available in between your scheduled sessions when appropriate.
- 2. FEE:** We have agreed on a per session fee of \_\_\_\_\_. Please plan to pay me each session. Sessions, when extended upon the agreed time, will be charged accordingly. It would be to your advantage to have your check prepared in advance of our meeting to further maximize our time together. Additional fees will be charged to the client in the event of necessary legal work or hospital visits. You are responsible for all fees not covered by insurance. If fees for services are not paid in full, utilization of a collection agency may be necessary.
- 3. INSURANCE:** If you have health insurance, please let me know and I will provide you with a monthly insurance statement, which you can submit to your insurance company for reimbursement. Please be aware that when you submit an insurance claim, that information (including diagnosis) may be stored in computer databases. This information may be accessible to other insurers such as life of disability insurance companies.
- 4. CANCELLATION:** The scheduling of an appointment involves the reservation of time specifically for you. Please inform me of your cancellation at least 24 hours in advance or you will be charged for the session.
- 5. TELEPHONE CALLS/EMERGENCY PROCEDURES:** If you need to reach me between visits, please leave a message on my voice mail with your name, day and evening telephone numbers, and the best time to reach you. I will return our call as quickly as possible. There is no fee for the occasional brief telephone call. However, I will need to charge you at the regular rate for frequent conversations or those over 10 minutes, which will be considered, phone sessions. I will let you know when I will be out of town or unavailable and my voice mail message will inform you of how to contact the colleague who is on call for me. In the event of an emergency, contact 911 or go to the nearest hospital.
- 6. EMAIL & TEXT:** Text are only to be used for cancellation and emergencies. I will not be using email due to confidentiality of client information.
- 7. CONFIDENTIALITY:** I am required by the Board of Behavioral Science Examiners to keep session notes, and if subpoenaed, I may be Legally obligated

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

- a. When there is a reasonable suspicion of child abuse to a dependent or elder adult.
- b. When the client communicates a threat of bodily injury to others.
- c. When the client is suicidal.
- d. Physical injury due to violence.
- e. When disclosure is required pursuant to a legal proceeding.

**7. OTHER RESOURCES:** I am available to share with you other resources including reading material, service organizations, health practitioners, attorneys, educational support services, etc. Please feel free to ask for these resources with the knowledge that I cannot be held responsible for the quality of other professionals' services and that these services and professionals are not affiliated with Cynthia Weston, M.S, L.M.F.T.

I understand that the purpose of the procedures will be explained to me and subject to my verbal agreement. I have read and fully understand this Consent for Treatment Form.

Client Signature/Date \_\_\_\_\_

Responsible Payor Signature/Date \_\_\_\_\_