AGREEMENT FOR PYSCHOTHERAPY SERVICES CONDUCTED BY GINGER PASKOWITZ, LCSW

Consent to treatment: By signing below you hereby give your full consent to receive the evaluation and treatment services of Ginger Paskowitz, LCSW until we determine that services are no longer appropriate or will no longer be provided. You also certify that you have the legal authority to authorize consent to this evaluation and/or treatment.

Client initials ___________ Client initials ___________

The process of therapy: Participation in therapy can result in a number of benefits to you, including improved interpersonal relationships and the resolution of specific concerns that led you to initially seek therapy. Working towards these benefits requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, it's progress, and other aspects of the therapy and will expect you to respond openly and honestly.

Therapy often includes discussing difficult topics which have caused your symptoms to develop. Remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. Or you may experience anxiety, depression, insomnia, etc. I may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel upset, angry, depressed, challenged, or disappointed. At anytime you may initiate a discussion regarding the possible positive or negative effects of participating in, not participating in, continuing, or discontinuing therapy. While benefits are expected from therapy, specific results are never guaranteed.

It is important to me that my clients feel safe during therapy to discuss anything that is relevant to their lives. As such, I take great care to respect all differing religious views, spiritual practices, personal values, political opinions, or cultural beliefs. In my work as a therapist, I do not disclose my own views or beliefs, but rather, we will explore together the views and beliefs that you feel are important and relevant to your life. I welcome clients from all races, cultural backgrounds, sexual orientations, sexual identities, religious or non-religious beliefs.

Client initials ___________ Client initials ___________

Cancellation and Late Arrival Policy: Office policy requires that 24-hour notice be provided before the cancellation of any therapy sessions, with the exception of serious emergencies or sudden and serious illnesses. Serious emergencies or serious illnesses include but are not limited to, the death of an immediate family member, natural disasters, or severe illnesses of an immediate family member sharing a residence with the client. Events not subject to exception, included by way of example, are business meetings, final exams, conflicting appointments or minor illness. The full session rate of $200 dollars will be billed for any late cancellations or "no shows" unless the office receives proper 24-hour notification. You may reschedule or cancel sessions by calling or leaving a message on my office phone or by sending an email (see consent for email communication on a separate form). Please note that many insurance companies will not reimburse you for missed sessions.

Appointments are to last no longer than 90 minutes. Clients arriving late will not be provided an extension of time beyond what they were originally scheduled so as not to disrupt other clients' appointments. There will be no reduction in fees for any shortened sessions resulting from a client's late arrival.

Please note that I will not be in my office on days in which the KISD schools are closed for inclement weather. If necessary, I will provide phone or skype sessions on those days, or we can reschedule for a different day. You will not be charged for the missed session due to weather related cancellations.

Client initials _________ Client initials _________

Privacy and Confidentiality: It is important to remember that our relationship is strictly professional and completely confidential. The identities of my clients are kept in strict confidence and will not be revealed without his or her express written permission. Likewise you are expected to keep our communications confidential and you understand that all records of communication between client and therapist remain the property of Ginger Paskowitz, LCSW.

We ask that you also respect the confidentiality of other people who you might see in the waiting room. I share a waiting room with three other clinicians. If you see someone you know in the waiting room, please respect their privacy and confidentiality.

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where law requires disclosure.

Disclosure may be required in the following circumstances:

1) Where there is a reasonable suspicion of child abuse/neglect or elder physical abuse,
2) Where there is a reasonable suspicion that the patient presents a danger of violence to others,
3) Where the patient is likely to harm him or herself unless protective measures are taken,
4) Disclosure may also be required pursuant to a legal proceeding (for example, if you are involved in a custody dispute or if you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the records and or testimony by me).

Most of the provisions explaining when the law requires disclosure were described to you in the Notice of Privacy Practices that you received with this form.

I occasionally consult with other professionals regarding my clients; however, the client's name or other identifying information is never disclosed. The client's identity remains completely anonymous and confidentiality is fully maintained.

Considering all of the above exclusions, if it is still appropriate, upon your request, I will release information to any agency/person you specify unless I conclude that releasing such information might be harmful in any way.

Client initials ____________ Client initials ___________

Harm to self or others: If there is an emergency during our work together to the point where I become concerned about your personal safety, the possibility of you injuring someone else or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, I may also contact law enforcement, hospitals, or an emergency contact whose name you have provided.

Client initials ___________ Client initials ___________

Confidentiality of the email, cell phone, text, and fax communication: If you choose to email me from your personal email account, please limit the contents to housekeeping issues such as cancellation or changing contact information. I will not respond to personal and clinical concerns via email. If you call me, please be

aware that unless we are both on landline phones, the conversation is not confidential. Likewise, text messages are not confidential, and **I will not text with my clients**. If you send a fax to me, my fax line is in a secure location. I encourage you to only communicate through a computer that you know is safe (i.e. wherein confidentiality can be ensured). **Note: There is a separate Email Consent Form.**

Client initials _________ Client initials ____________

Fees: Services will be provided for a fee of $200 per session. Payment for services is due at the end of each session. I am happy to provide you with a receipt for services that includes all the information you need to file a claim with your insurance company. I will accept payment in the form of cash, personal check (made out to Ginger Paskowitz, LCSW), or via PayPal. I am not accepting credit card payments at this time.

Client initials _________ Client initials ____________

Telephone and emergency procedures: If you need to speak with me between sessions, please call 281-456–3941. Please leave a message and your call will be returned as soon as possible. Messages are checked daily, but never during the nighttime. Messages are check less frequently on weekends and holidays.

Client initials _________ Client initials ____________

Emergency contact: I am not available 24/7. If you are in a crisis and need immediate help please call 911, go to the nearest emergency room, or contact the crisis hotline at 713-HOTLINE. Teen line: 713-529-TEEN. You may also contact 1-800-SUICIDE or 1-800-273-TALK. If a life-threatening crisis should occur, you agreed to contact a crisis hotline, call 911, or go to a hospital emergency room.

Client initials _________ Client initials _____________

Your signature below indicates that you have read and understand this informed consent, the Email Consent Form, and the HIPPA Notice of Privacy Practices.

____ _______________________

Signature of Client Date

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Printed name of Client

____ _______________________

Signature of Client Date

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Printed name of Client