DEBRA GILL PSYCHOLOGICAL SERVICES
124 EAST MOUNT PLEASANT AVENUE, 2ND FLOOR
LIVINGSTON, NJ 07039
(973)820-5174
WWW.DEBRAGILL.COM

Informed Consent Agreement

I, _____ am seeking psychological services from Dr. Debra Gill, NJ Licensed Psychologist (#4341) beginning _____ (today's date).

For minor clients whose parents are paying for sessions:

My child_____ is seeking psychological services from Dr. Debra Gill, NJ Psychologist (#4341) beginning _____ (today's date).

Please initial below to indicate that you have read and understand each item. For children 14 and over, please have parent and child both initial.

Please ask Dr. Gill for clarification of any item you do not understand. Thank you!

CONFIDENTIALTY

___ I understand that information shared during provision of services in session will be kept confidential by the therapist except as provided by law. The primary exception is a situation in which the therapist believes the client poses an immediate danger to him/herself or others and sharing certain information is necessary to provide protection.

EMERGENCY CONTACT

___ In the event of an emergency, consent is hereby given to contact the following

Individual:_____ relation to you? _____

Phone #'s: _____

ELECTRONIC COMMUNICATION

___ I understand that the therapist cannot guarantee privacy when information is shared electronically, However, precautions to protect confidentiality will be

taken. These precautions include exclusion of identifying information whenever possible and encryption of emails that include identifying information.

CONTACT METHODS FOR SCHEDULING

—— Scheduling appointments is often facilitated by use of text messages, email messages and voice-mail messages. Your permission to use these forms of communication is requested:

—— Text messages okay. # _____

—— Voice mail messages okay (#'s) _____

—— Unencrypted Email messages okay (email):_____

COORDINATION OF CARE WITH OTHER PROFESSIONALS

Yes No Are you taking medications for mental health prescribed by a psychiatrist or other medical professional?

If yes, please include the psychiatrist's or Dr.'s name and phone number below so Dr. Gill may learn more about your treatment history and coordinate care.
Consent is hereby given** to contact my psychiatrist/person prescribing medications

—— Psychiatrist's name and # _____

In some cases, other professionals may have information relevant to your care, such as an endocrinologist, gastro-intestinal (GI) specialist, nutritionist, primary doctor, etc. If there are professionals you would like Dr. Gill to be able to speak with when/if the need arises, please provide relevant information and consent below:

—— Consent is hereby given** to contact the professionals named below to facilitate my care. I hereby give permission to release information necessary for treatment coordination and understand that I may place limits on information released. Dr. Gill will discuss with me any contacts she wishes to have with these professionals before making them.

—— Specialty_____ name, #_____

—— Speciality _____name, #_____

**Signature for Releases of Information_____

FEES and CANCELLATION POLICY

—— I understand I am responsible to pay fee at time services are delivered (unless alternate arrangements are made with Dr. Gill and indicated here)

—— **I understand that if I (or my minor child) miss a scheduled session, I am responsible to pay the full session fee.**

—— I understand that a phone session billed at the regular session rate may substitute for a missed-session fee or for a late-cancellation fee when I (or the minor client) is physically unable to attend a scheduled session.

—— **I understand that IF I NEED TO CANCEL a scheduled session, I must do this 36 HOURS PRIOR to the appointment time to remove my obligation to pay for the session.** (For example, if my appointment is for Friday at 10:30AM, it must be cancelled by Wednesday 10:30pm.**)**

—— Dr. Gill may SOMETIMES waive a late-cancellation fee at her discretion, or she may indicate at the time of scheduling that the cancellation fee will not apply to a particular session. **I understand that waiving a late-cancellation fee in one instance does not imply that the fee will be waived in any future instance.**

—— **Fee for initial assessment session (60 minutes) is $_____**

—— **Fee for a typical treatment session (45 minutes) is $_____**

INSURANCE

—— Dr. Gill is an out-of-network provider (except for medicare). As a service to me, she will electronically submit claims for our sessions to my insurance company using information I provide. This should help me receive some reimbursement based on my out-of-network benefits (or medicare benefits), although reimbursement is <u>not</u> guaranteed by Dr. Gill and depends on my insurance plan and whether I've met my deductible.

—— I understand that Dr. Gill will make every attempt submit information correctly and correct any errors. However, Dr. Gill **does not have time to call** my insurance company or negotiate reimbursement plans on my behalf.

—— I understand that **upon my request**, Dr. Gill will provide a receipt for payments I've made that is suitable for me to submit by mail or fax to my Flexible Spending Plan or Insurance plan.

TREATMENT PROGRESS and TERMINATION OF TREATMENT

- ___ I understand that Dr. Gill and I will work together on an ongoing basis to identify my needs, develop treatment goals and outline a treatment plan.
- ___ I understand that treatment for behavioral problems requires effort and active participation on my part, both during and between sessions.
- ___ Generally, the more open and honest I am during sessions about my feelings, thoughts and behaviors, the more benefit I am likely to get out of treatment.
- ___ I understand that uncomfortable feelings are often a part of successful therapy and that managing these feelings without engaging in harmful behavior are important skills I can learn during treatment.
- ___ I understand that I will get more out of my work with Dr. Gill if I complete the practice exercises she assigns, try to engage in behaviors that move me towards my goals, and avoid harmful behaviors, as per my commitments.
- ___ I agree to discuss any concerns regarding services or fees with Dr. Gill.
- ___ I understand that, as the client, I may terminate services at any time, though this decision is usually made collaboratively between therapist and client.
- ___ Once a decision is made to terminate, I understand that it is very helpful, though not required, to have a final review session with the therapist to summarize progress made and clarify reasons for ending treatment.

I have read and understand the material presented above and I voluntarily give my informed consent to these arrangements.

_____

Signature of client (or of parent/legal guardian if applicable)

_____
Date

_____
Signature of minor client over 14

_____
Date