Belinda A. Walker, Ph.D.
Licensed Psychologist

INFORMED CONSENT FOR TREATMENT

Overview of Therapy: As a Licensed Psychologist, I am trained in a broad range of therapeutic techniques. The goal of therapy is to help you resolve the problems for which you are seeking treatment. Please know that while it is impossible to guarantee any specific results regarding your therapeutic goals, I will work with you as conscientiously and diligently as I can to achieve the best possible results. If at any time, you have questions about your therapy, are dissatisfied, or have questions about my services, please let me know. Other treatment options and/or referrals will be provided as deemed appropriate. Psychologists are not medical doctors and do not prescribe medication. I do, however, work closely with physicians in providing information that helps in the coordination of medical and psychological care.

It is important for you to realize that our relationship is professional rather than social. Ethically, I am bound to avoid "dual relationships." I am not allowed, because of the ethical boundaries of my profession, to advise you from other professional viewpoints such as law, medicine, finance, etc. Our contact, other than chance meetings, will be limited to appointments you arrange with me. I cannot attend social gatherings, accept gifts, or form a relationship in any other way than in the professional context of our sessions. These guidelines have been established by the profession to protect you, the client.

Confidentiality: The information that you provide in therapy is confidential and will not be shared with others without your written consent. However, there are a few circumstances when confidentiality will not be maintained.
These include:

- Concerns of imminent harm to self and others (i.e., suicide or homicide, respectively)
- Crucial information about physical or emotional well-being of the client
- Being sued by the client
- Suspicion or knowledge of child/elder abuse
- A judge or district attorney's office mandating the release of records
- Mental health services (e.g., disability)
- Collection of any outstanding balance
- Any other situation required by law.

Coverage/Emergencies: In case of emergency, call 911 or go to the nearest emergency room. Phone calls can usually be answered within the same business day or next business day. Please remember to leave your name, a brief message and always leave a **call back phone number** to expedite the handling of your call. Dr. Walker does not email, text, or provide any private patient information via technology other than verbal phone calls.

Sessions/Fees: Therapy sessions are usually 45 minutes in length. The remainder of the hour is used to chart notes, return client phone calls, consult with other professionals, etc.
A responsible parent or adult must be present for the entire session for children under the age of 16. It is highly encouraged that other arrangements be made for siblings of minor clients. Parents are often a part of sessions and it is more beneficial if a parent's attention is not divided from the therapy session. The initial office visit fee is $175.00. The fee for subsequent visits is $145.00. Any monies owed are due upon services being rendered. Acceptable forms of payment are cash, check, money order, and any major credit/debit card. There will be a $25.00 service charge levied on all returned checks. Should six (6) or more consecutive month lapse in your treatment, you will be considered a "new client' upon your return, and new client procedures/fees will apply. Dr. Walker does not accept or file insurance. Clients are provided sufficient information at each appointment in order to file for reimbursement.

Appointments/Cancellations: Except for the initial appointment, my staff does NOT call to confirm appointments. Your appointment time has been specifically reserved for you; being on time will ensure that you receive the full time scheduled. If you cannot keep a scheduled appointment, please cancel the appointment at least 24 hours in advance (to avoid being charged) so that someone else may have the opportunity to be seen for treatment. Regarding your appointment, the following will apply:

- There is no charge for cancellations 24 hours prior to the scheduled appointment.
- There is a **$45.00** charge if you do not provide 24-hour advance notice prior to your scheduled appointment. This charge will be billed to you and is due on or before your next scheduled appointment.
- There is a **$145.00** charge (full appointment fee) if you fail to keep your scheduled appointment without 24-hour advance notice ("no show"). This charge will be billed to you and is due on or before your next scheduled appointment.
- If you are late for your scheduled appointment, you will be seen only for the remainder of the scheduled appointment. Unfortunately, there are times when I am behind schedule due to therapeutic issues in a particular session; in this case, you will receive the full 45 minutes of the scheduled appointment.
- Chronic tardiness and/or missed appointments (i.e., "no show") is a therapeutic problem and will be addressed with the parent or adult client. Commitment to the therapy schedule is crucial for successful treatment. If this is a significant problem I may no longer be able to work with you. If treatment is terminated appropriate referral sources can be provided at client request.

Clients Rights: I understand that I have chosen to undergo therapy, that this choice is voluntary, and that I may terminate treatment at any time. I understand that there is no assurance that I will feel better. As therapy is a cooperative effort between my psychologist and me, I will work in a cooperative manner to resolve my difficulties. I understand that during the course of my treatment, material may be discussed which will be sensitive in nature and that this may be necessary to help me resolve my problems.

I understand that my insurance/managed care company may contact my psychologist to insure continuity and quality of my treatment, or after completion of my treatment to assess the outcome. I also understand that my psychologist will not communicate with this company without my written permission that I must provide.

I understand that my psychologist and physician may exchange any and all information pertaining to my therapy, to the extent that such disclosure is necessary for case management and coordination of treatment. I understand that I can revoke my consent (in writing) at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. If I do not revoke this consent, it will expire automatically one year after treatment is terminated.

I have read and understand the policies.

Client Name: _____ DOB: _____/_____/_____

_____ Date: _____/_____/_____
Signature of Client/Parent/Legal Guardian