

Kathleen Young, Psy.D.  
Arizona Licensed Psychologist, #4205  
520-261-0265

### Informed Consent for Participation in Treatment

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Please read this consent form carefully, as it describes the policies and procedures followed by your psychologist. You will receive a copy of this form.

#### ***Types of Service Provided by Your Psychologist:***

You will be interviewed and may be asked to fill out some questionnaires to assist the psychologist in determining how best to help you. Treatment usually involves individual meetings with the therapist, but may also include group treatment and/or involving family members or significant others in some individual sessions. All treatment will be conducted only with your consent.

#### ***What You Can Expect from Treatment:***

The duration of treatment is different for each person and can be difficult to estimate; your therapist will address any concerns that you have about this. If you are not feeling satisfied with your treatment for any reason, you are asked to discuss this directly with your therapist. The therapist will work with you to uncover what might be preventing progress, will modify goals with you if appropriate, and will make a referral for you to (an)other professional(s) if necessary, and/or at your request. Sometimes people find that they have a temporary increase in their level of distress when beginning psychotherapy, because the process of working on personal issues can be difficult; please be aware of this and discuss it in therapy if it is a concern.

#### ***Confidentiality:***

What you discuss with your psychologist is kept confidential, or private, with some exceptions. The **Notice of Privacy Practices** provides detailed information about how private information about your health care is protected and under what circumstances it may be shared.

#### ***Fees for Services:***

Payments for services must be made at the time of each session. If you use insurance to pay for treatment, you can be provided with a completed invoice/billing form to submit to insurance. Some companies will reimburse you for your services with an out-of-network provider. The following fees are charged for services:

Initial Assessment Session = \$150.

Therapy Session (45 minutes) = \$150. Therapy Session (30 minutes) = \$75.

#### ***Cancellation policy:***

You will be billed at your full fee rate if you miss an appointment without providing at least 24 hours notice. (Insurance will not be billed; this is charged to you.)

**Please initial one of the lines below and then sign to indicate that you have read and understand: 1) this Informed Consent form for participation in treatment, 2) the Notice of Privacy Practices form and how information about you may be used or disclosed, and 3) that you consent to treatment and the provisions in the *Informed Consent and Notice of Privacy Practices* form.**

\_\_\_\_\_ I authorize my psychologist to release information about me as necessary to my insurance company for billing purposes to assist with my reimbursement. I am responsible to pay all fees upfront.

\_\_\_\_\_ I do NOT authorize release of any information about me or my treatment to an insurance company. I am responsible to pay all fees.

\_\_\_\_\_  
Signature and Date

\_\_\_\_\_  
Signature of Parent /Legal Guardian Date Signature of Second Parent/Guardian and Date

\_\_\_\_\_  
Printed names of Parents or Legal Guardians or Personal Representatives (if applicable)