TORI DABASINSKAS, MFC, LPCC

WA LICENSE: LF60424732
CA LICENSE: MFC37796

Informed Consent

Agreement for Services for _____

Scheduling and Fees: The fee for services will be $150 per session for up to six months. The fee may be reevaluated at that time. Sessions are 50 minutes long. When you make an appointment, that time is reserved for you. Please give 24 hours notice if you need to cancel or you will be charged for the time reserved. If we can reschedule the appointment or another time during the week at a time convenient for both of us, the fee will be waived. When another party (such as an HMO or a church) is responsible for paying part of your therapy, and a session is missed due to lack of 24 hours notice, you are responsible for paying the fee. Payment is made at the beginning of each session.

Confidentiality Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:

1) Suspected abuse or neglect of a child, elderly person or a disabled person,
2) When your psychiatrist or therapist believes you are in danger of harming yourslf or another person or you are unable to care for yourself,
3) If you report that you intend to physically injure someone the law requires your tharapist to inform that person as well as the legal authorities,
4) If your psychiatrist or therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc.
5) When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc,
6) In natural disasters whereby protected records may become exposed or
7) When otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other professionals or family members.

I have read and understood the above information as well as the Client Information and Office Policy Statement. I accept, understand and agree to abide by the contents and terms of these agreements and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Client Signature _____ Date _____

12826 SE 40TH LANE, SUITE 203
BELLEVUE (FACTORIA), WA 98006

P (925) 785-0558