JAMES M. CONTI, Ph.D., LLC

Licensed Psychologist

Licensed Marriage & Family Therapist, Certified E-Therapist, Certified Advanced Imago Relationship Therapist, Certified Imago Workshop Presenter, Certified Gottman Therapist, Certified Advanced Alcohol & Drug Counselor, Approved Consultant American Society Of Clinical Hypnosis

I agree to and understand the following conditions of treatment with James M. Conti, Ph.D., LLC, and/or his associates:

1. AUTHORIZATION FOR TREATMENT: Signing this agreement authorizes treatment including psychotherapy/counseling, psychological testing/evaluations, hypnosis, and other behavioral health clinical care with James M. Conti, Ph.D., and/or his associates.

2. CONFIDENTIALITY: Information shared within the confines of treatment will be held strictly confidential except for what the law deems as mandated reporting to authorities which includes: (1) Being suicidal or a danger to self in any way; (2) Being homicidal or intending to physically harm another person(s); (3) Suspicion of or actual child abuse; (4) Suspicion of or actual elderly abuse; (5) Suspicion of or actual abuse of disabled people; (6) Due to the "Patriot Act" (known legally as "Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism Act") we may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government; (7) Records may be subpoenaed and shared with court without permission of patient/client, however, we will exercise every effort to avoid release of records under privacy and confidentiality laws; (8) Excluding items 1-7 above, an "Authorization for Release of Confidential Information" form must be signed to release any confidential information; (9) If using insurance to pay for treatment by signing this document you authorize release of confidential information to your insurance company for payment, authorization for treatment, review of treatment/records, and coordination of care.

3. FEES: All out of pocket fees are due at the time of service. If insurance is utilized, co-payments and co-insurance must be rendered at the time of service (not billed to patient). *It is the patient's responsibility to call their insurance company prior to the initial session to determine their benefits including deductible and copayments. If the insurance company does not ultimately pay for sessions the patient will be responsible for said payments.* An administrative fee will be added to credit/debit/HSA card charges of 5% but cash payments or other electronic methods of payment such as Venmo should not incur any fee. A collection service may be initiated for delinquent accounts including missed appointment fees.

4. APPOINTMENTS: Appointments must be canceled 24 hours prior to scheduled appointment time. Missed appointments are subject to a $75 missed appointment fee to cover the time. Consideration will be given for bonified emergencies. An online or phone session may be used if unable to physically get to the office for a scheduled session (which will prevent a missed appointment fee). If you miss your appointment we may not continue your treatment until missed appointment fees have been paid. Initial services will not be provided to individuals in disagreement with this missed appointment policy. *Please remember that you signed this agreement.*

5. SESSION LENGTH: Sessions are generally 45 to 50 minutes in length, following insurance company standards. Please note that ALL paperwork requested by patients or required such as authorizations, calls to insurance companies, documentation for disability, FMLA, attorneys, DCF, etc., will be completed during scheduled sessions. Requested written documentation done outside of sessions will incur a fee at a rate of a minimum of $200/hour.

6. THERAPEUTIC/COUNSELING PROFESSINAL RELATIONSHIP: Due to professional ethics, the patient/client-psychologist/therapist relationship must remain strictly professional; psychologist/therapist and patient/client may not enter into any other relationships such as social, business, sexual, etc. The psychologist/therapist may share information related to their education, training, licensure, certification, and clinical experience as it relates to treatment. The psychologist/therapist generally will not discuss specific information regarding their personal life to maintain professional therapeutic boundaries.

7. COUPLES THERAPY: The "couple" is considered the patient/client. Any information shared with the therapist in the absence of one partner via email, text, verbally or by any other means may be shared with the other partner in the next session by either the disclosing patient/client or psychologist/therapist. Couple treatment may be discontinued by the psychologist/therapist if these intended "secrets" are not disclosed accordingly.

_____**Date**_____	_____**Date**_____	_____**Date**_____
Signature of patient/client	***Signature of 2nd patient/client***	***Signature of psychologist/therapist***

Please complete the following only if you are bringing a child/minor for counseling and you are their parent/legal guardian:

8. CHILD THERAPY: Children and adolescents have the right to confidentiality of information shared within a session. The boundaries of this confidentiality will be agreed upon at the onset of therapy between psychologist/therapist, parent(s)/legal guardian(s) and child/adolescent. Only one parent/legal guardian must sign to authorize treatment for their minor(s).

I acknowledge being the parent/legal guardian of _____**DOB**_____ and authorize treatment with James M. Conti, Ph.D., LLC, and/or his associates. I have determined and agreed that my child(ren)'s confidentiality will be limited to:_____

Name of parent/legal guardian _____ **Signature of parent/legal guardian** _____**Date**_____