Andrea L. Schneider, LCSW
150 N. Walnut Ave., Suite J
San Dimas, CA 91773
(626)-241-6812

CONFIDENTIAL INFORMATION

ADULT CONSENT FOR TREATMENT

I, _____, agree to participate in therapy with Andrea Schneider, LCSW, as my therapist beginning_____(date of first visit).

Appointment Fees: Therapy sessions consist of a 50 minute hour (in some cases 90 minutes). The fee for a 50 minute hour is $150.00. The fee for 90 minutes is $250. Payment for services is due and payable at the time professional services are rendered. Please have your check ready at the beginning of the session so our attention can be given immediately to the work at hand. If I encounter a problem with the payment I shall discuss it with the therapist immediately. Appointments cancelled or rescheduled with less that 24 hours notice may be charged a cancellation fee of $100.00. Insurance will not pay for a "no-show" for session; therefore, I am responsible for the full amount of the fee if I "no-show" for a session.

Insurance Reimbursement: It is my responsibility to check with my insurance company to determine if there is coverage for mental health, the amount of the annual deductible, if it has been covered at the time of service, and if additional documentation is required. I am responsible for the co-payment at the time of the service. I understand what may be quoted by my insurance company may not be the actual payment to the therapist, and I will be fully responsible for payment if insurance does not pay the claim for service.

Confidentiality: All information disclosed within the client's therapy sessions, including case notes and records, will be treated as confidential and, under some circumstances, as privileged. No information will be revealed to anyone not present in therapy without the permission of the client or a legally authorized representative unless there is an applicable legal or ethical exception. However, the therapist is required by law to report any suspected child, elder or dependent adult abuse and any situation where the client threatens violence to an identifiable victim. The law also permits the therapist to break confidentiality when the client presents a danger of violence to others or is likely to harm him or herself unless protective measures are taken. In addition, disclosures may be required in certain legal proceedings and actions.

All questions regarding confidentiality, the release of information and waiver or privilege, etc., need to be brought up with the therapist.

Termination: The client's therapeutic and financial relationship with the therapist continues as long as the therapist is providing professional services until the client informs him or her that the client wishes to terminate therapy, or the therapist notifies the client that therapy is being terminated.

I agree to meet with the therapist at least once before stopping therapy. I understand that this requirement is in my best interest. I agree to pay for all services provided up until the time the therapy relationship is terminated.

The treatment consists of weekly sessions, unless otherwise determined mutually by the therapist and client.

I have read and understand all of the terms and conditions stated above regarding therapy. All my questions have been answered fully. I understand and agree to the terms and conditions of this treatment.

_____ _____ _____

Signature of Client Printed Name Date

I have disclosed the above issues with the client. My observations of this person's behavior and responses give me no reason to believe that he or she is not fully competent to give informed and willing consent to treatment.

_____ _____ _____

Signature of Therapist Printed Name Date

___ Copy given to client ___ Copy kept by therapist