

**Linda S. Levi, MA., LCPC**

**Consent To Treatment**

**General Information:**

Welcome to my office. This form is designed to help explain some aspects of our work together so that we may have a mutual understanding regarding the process of therapy. Therapy is just that, a process. Since we will likely work together for weeks, months, or even years, I encourage you to ask questions about any aspect of therapy that concerns you at any point in time during the treatment process. The goals of treatment and methods used to achieve those goals are open to discussion and evaluation at any time.

While we will work to achieve maximum benefit from this treatment, there is no way to guarantee such benefits or particular outcomes. To be effective, the process of therapy may entail exploring difficult and often painful issues. As a result you may experience emotional strain, and at times you may feel even worse during treatment as these painful issues are explored. Regular attendance will produce the maximum benefit in this work, and allow us maximum ability to address these issues, however, you are free to discontinue treatment at any time of your choosing.

Although a number of professionals work in this suite Linda S. Levi LCPC works independently and is a separate entity.

**Messages & Emergencies:**

A voice mail system answers my phone when I am not available, and I check messages regularly. Hours during which you may expect a return phone call are between 10:00am and 9:00pm. Monday-Friday. I will return your call as quickly as I can. **I do not regularly check for messages during the weekend.** In case of an emergency requiring immediate therapeutic assistance you may call The Crisis Line at (630) 482-9696. If I am unable to get back to you as quickly as you require, or if you feel the emergency is beyond the scope of what might be able to be handled by phone, please get to the nearest emergency room or call 911 for assistance. When I am out of town, emergency phone calls will be covered by a licensed therapist and you will be provided with the name and number at that time.

**Confidentiality:**

Conversations between us will almost always be kept confidential by me. Please be aware that to most effectively help you I may need outside consultation from another trained therapist. I work diligently to protect your identity by **never** sharing your name or other identifying information that might compromise confidentiality. There are times where these principles will not apply. 1) If you choose to use insurance benefits, you need to be aware that all insurance policies require a diagnosis. Some companies require information about our work together (content, issues being worked on), and dates of sessions. 2) **By law** I am required to report actual or suspected child or elder abuse to the appropriate authorities. 3) I am legally bound to protect anyone whom you threaten with violence or to cause physical harm or other dangerous actions; including yourself. If

such incidents arise, I will need to break the confidentiality of our communications. Whenever possible, I will make reasonable efforts to resolve these situations before breaking confidentiality.

**Appointments & Cancellations:**

I will make every attempt to reserve a regularly scheduled appointment time for you. I will also make **every** attempt to not miss appointments. I ask that you please do the same. If you need to miss a session I ask that you 1) give me 24 hours notice so that I may attempt to fill your time, or 2) reschedule your appointment within 7 days. If neither of those options can happen, you will be responsible for paying for the missed session. Payment in full for missed sessions is expected at the time of our next scheduled appointment. Please be advised that many insurance companies do not reimburse for missed sessions.

**Payment:**

To minimize administrative costs, I request that you pay me at the time of service and submit the monthly statement you will receive to your insurance company (if you are utilizing such benefits) and have your insurance reimburse you. If you would like to receive a statement more frequently, I will gladly oblige.

Your signature below assumes you have read, understand, and agree to abide by the above. It also assumes that you give your consent for me to provide you with psychotherapeutic services.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature  
(or Parent/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Linda S. Levi, MA., LCPC

\_\_\_\_\_  
Date