maui PSYCHOTHERAPY
Amita Schmidt, LCSW
95 East Lipoa St. #209
P.O.Box 1346
Kihei, HI 96753
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Client Consent

Please read the following information carefully; feel free to discuss any questions you may have. **Your initials next to each item mean you have read and understood the information.**

_____ *initial* 1. I have requested services from Amita Schmidt, LCSW and hereby consent to receive services from Amita Schmidt, LCSW.

_____ *initial* 2. I acknowledge that I have received a copy of "**Office Policies and General Information**." This document includes information on Client Rights, Fees and Financial Policies, Insurance Issues, Confidentiality, and other areas related to my therapy. I understand and agree to abide by the policies within this document.

_____ *initial* 3. All communication between a licensed therapist and client will be held in strict confidence subject to state and federal law. In the following instances my therapist is required to break my confidence: if I (client) allege abuse or neglect of minors, elderly or handicapped individuals; if I am a threat to my own or someone else's life; or if a court of law orders disclosure.

4. I may choose to use insurance benefits to help pay for my therapy. If so:

_____ *initial* a. It is my responsibility to know my benefits. All charges not covered by my insurance are my responsibility including co-pays, deductibles and charges not covered by my insurance benefits.

_____ *initial* b. My signature on this form allows my therapist to release to my insurance and/or managed care company any information they require to authorize and manage treatment, to process the claim, and to directly pay my therapist the insurance portion of incurred expenses.

_____ *initial* 5. Amita Schmidt, LCSW's phone number is 808 347 6217 and has a 24-hour voice mail. My therapist will return calls as soon as they possibly can. If I am in extreme crisis, I may call 911 or the national Mental Health Crisis Center 800 273 8255 and/or go to the nearest Emergency Room.

_____ *initial* 6. I agree to pay a cancellation/no-show fee of $60.00 in the event that I do not keep a scheduled appointment and have not given 48 hours cancellation notice.

_____ *initial* 7. I understand that this process can bring up uncomfortable feelings and reactions, such as sadness, anxiety, anger, and so on, and that my therapist and I will work on these feelings together in therapy.

_____ *initial* 8. I understand that Amita Schmidt, LCSW does not engage in, and is not available to assist me with any court or legal proceedings.

_____ *initial* 9. I have received a copy of the HIPPA notice of Privacy Practice.

_____ *initial* 10. I understand that all communication via text, emails, and phone calls are not protected communications and have the potential for client information to be inadvertently exposed. I have been fully informed of the risks and take full responsibility for any breach in confidentiality that may result from said communications. I understand that Amita does not use texts or emails as a form of therapy.

I have read and understood and agree to these policies and I agree to abide by them.

_____

(Print) Client Name | Signature of Client or Responsible Party | Date

_____

Therapist Signature | Date