Millyan Cabrera, LMHC, RPT, NCC
4100 W. Kennedy Blvd. Suite 120, Tampa, FL 33609
(813) 391-3610
millyanc@verizon.net

Informed Consent and Service Contract

1. I am voluntarily seeking mental health counseling for myself and/or my minor child. I understand that counseling is expected to beneficial and effective, but there is no guarantee. Level of motivation is a contributing factor to success. The first few sessions will be focused on gathering information, assessing, identifying problems, and setting goals; future sessions will be aimed at attaining goals and addressing issues that arise between sessions.

2. **Appointments, Fees & Payment**

A. Sessions are 45 minutes long
B. Session fee: $120
C. Method of payment: [ ] self pay [ ] Insurance [ ] EAP _____ sessions
D. **Service charge for broken appointments with less than 24 hours notice: $60**
E. Payment is due at time of service.
F. Professional services not covered by insurance (i.e. reports or summaries of treatment, consultation with other professionals, school observations, lengthy email / phone communications): $120/hour.
G. Legal proceedings (professional time, preparation, transportation), even if therapist is called to testify for another party: $250 per hour, 4-hour minimum, plus therapist's legal fees if legal counsel is deemed necessary.
H. I am responsible for ALL charges incurred, including charges not covered by insurance. If a third party is needed for collection, name and demographic information may be disclosed, but health information will remain confidential**.**
I. **Credit card information is to be provided on ADDENDUM form.**

3. Employee Assistance Program (EAP) Benefits and Health Insurance

EAP is a benefit provided by the employer. It provides a limited number of sessions for assessment/referral and/or short-term problem resolution. Longer term care beyond the EAP may be paid through health insurance or self-pay. Using health insurance requires a mental health diagnosis, and it creates a permanent record of treatment. I authorize the therapist to provide the insurance company with all information needed to process claims.

4. The therapist does not accept cases that involve disability or "return to duty" status.

5. Social Media: Therapist maintains professional boundaries by not responding to "connection" requests.

(please turn over for page 2)

6. Phone Messages

The therapist's voice mail is confidential, and I may leave a message at any time. The therapist will contact me as soon as possible, using method(s) indicated at the bottom of this form. In case of life-threatening emergency, I am to call 911, or go to the nearest hospital.

7. Confidentiality

FL law and the guidelines of the counseling profession require written permission to share confidential information, with the following exceptions:

- disclosure of abuse of a child, an elder or vulnerable adult;
- disclosure of intent to harm self or someone else;
- a legal case where clinical records are subpoenaed by a court of law;
- other instances in accordance with HIPAA (Heath Insurance Portability and Accountability Act)

Minor Children: the same general principles of confidentiality apply to minor children. The therapist will disclose the child's progress and suggestions about how I might best participate in treatment. The content and scope of appropriate disclosure will be at the therapist's discretion.

8. Risks of Counseling

Risks of counseling may include experiencing or intensifying unpleasant feelings and taking responsibility for unresolved problems. Change is another possible risk because it upsets the balance in a relationship or family. This would be natural and expected. It plays an important role in the therapeutic process. The therapist will discuss any concerns I may have at any point in the counseling process.

9. I will accept messages from the therapist in the following manner (check all that apply):

[ ] Contact phone number [ ] Text message [ ] E-mail [ ] Home address

10. ***I have received a copy of the Notice of Privacy Practices.***

I have read this contract, agree to these terms and consent to treatment.

Signature	***Print Name***	***Date***

Signature	***Print Name***	***Date***