DONNA J. CORBETT, LCSW AND ASSOCIATES, LLC
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RUTHERFORD, NEW JERSEY 07070
201.815.1442

PSYCHOTHERAPY CONSENT FORM

I have chosen to receive psychological services from Donna J. Corbett, LCSW and Associates, LLC. My participation is voluntary and I am aware that I may discontinue receiving services at my discretion.

I understand that all of the information I disclose to in the course of treatment is held in the strictest of confidence and may not be released without my written consent. There are some exceptions to this which are allowed or mandated by state and federal law. Some exceptions to confidentiality include situations where there is:

- A danger to myself or another person
- Actual or suspected abuse or neglect of children/minors or the elderly (Licensed clinicians are mandated by law to disclose this information to the proper authorizes)
- Presentation of a valid court order

My psychotherapist may disclose any and all records pertaining to my treatment to my insurance company and/or primary care physician as necessary for coordination of treatment, submission and validation of claims, or case management. I may revoke this consent in writing at any time.

I have been informed of the costs of services. While Donna J. Corbett and Associates, LLC may submit my claim to my insurance company, I understand that I am responsible for the costs of services. I have been encouraged to contact my insurance company to determine the scope of mental health services covered by my policy.

I understand that I am responsible for the full service fee if I should fail to give 24 hour notice to cancel an appointment. Service fee for patient is $130.00, payable by the patient at the following visit, not billed to the insurance company.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a manner to resolve my difficulties. I understand that some of the information discussed in the course of psychotherapy may be necessary to help me resolve my concerns; I understand that alternatives to psychotherapy may be necessary to help me resolve my concerns. I understand that alternatives to psychotherapy include medication treatments or no treatment.

Signature Date

Witness Date