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IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of service for service.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial. As with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. While I cannot guarantee these benefits, my intention is to work with you to help you attain your therapy goals.

COUNSELING: Your first visit will be an assessment session in which you and I will identify your concerns, and focus on how we can work together to help you achieve your therapeutic goals.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist.

If you must cancel or reschedule your appointment, please call the office at 904-770-9717 at least 24 business hours in advance, otherwise it will be necessary to charge a late cancellation or no show fee. Please Initial here: _____

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. I request that payment be made before your session begins. If you are using insurance benefits for insurance that I take, I will file insurance claims for you, and I will honor any contractual agreements. If you have out of network insurance benefits, I expect full payment at the time of service, and I will provide you with a statement/receipt for services rendered.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact the office regarding the nature and urgency of the circumstances. I will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: I follow all ethical standards prescribed by state and federal law. I am required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; admitted prenatal exposure to controlled substances that are potentially harmful; suits in which the mental health of a party is in issue;

situations where the Therapist has a duty to disclose, or where, in the Therapist’s judgement, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departures from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including but not limited to, the person in danger.

I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name:

Telephone Number:

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given an opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receive mental health services including assessment and treatment, and I understand that I may stop such treatment or services at any time.

Signature – Client/Parent

Date

Signature – Spouse/Partner/Parent

Date

Therapist

Date