INFORMED CONSENT

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This document is intended to inform you of my business policies and your rights. After reading the document, if you have other questions or concerns, please let me know and I will try my best to give you all the information you need.

PARTICIPATION IN COUNSELING: The process of participation in counseling can result in a number of benefits to you including improving interpersonal relationships and resolution of the specific concerns that lead you to seek therapy. Counseling requires your active involvement and openness. I will ask for your feedback and views on our progress and other aspects of our sessions and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. I am likely to draw on various psychological approaches depending on what I believe will be of benefit . These approaches include, but are not limited to, behavioral, cognitive, psychodynamic, existential, family system, developmental, humanistic, and psycho-educational. Within a reasonable amount of timeafter the initiation of treatment, I will discuss with you my working understanding of the problem. If you have any unanswered questions about procedures used in the course of counseling or about the treatment plan, please ask. I look forward to working with you and will do my best to assist you in accomplishing your goals and enhancing your quality of life.

PAYMENTS AND INSURANCE REIMBURSEMENT: My fee is $150.00 for the initial session and $120 per session thereafter. As a courtesy, I will bill your insurance company, HMO, responsible party, or third party payer. I ask that you pay your co-pay at the time of each session. If you have a deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment, the balance is due at that time. I request that you authorize payment of medical benefits directly to Nancy Abramson MA, LPC LLC. If your account has not been paid for 60 days, I have the option of using legal means (courts, collection agencies, etc.) to obtain payment. If such legal action is necessary, its costs will be included in the claim. There is a returned check fee of $25.00. Since the scheduling of an appointment involves the reservation of time specifically for you, there is a fee of $50 for any missed appointment not cancelled within 24 hours.

TERMINATION: You have the right to terminate counseling at any time. Furthermore, if I do not feel that I can be of service to you, I retain the right to terminate services. In such circumstances, I will do my best to provide you with the names of qualified professionals.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Our verbal communication and clinical records are strictly confidential except for: a) information shared with your insurance company or this provider's billing company in order to process your claims, b) information you and/or your child reports about physical, emotional, or sexual abuse or elder abuse; then, by NJ State Law, I am obligated to report this to the Division of Youth and Family Services or Adult Protective Services, c) If you sign a release of information to have specific information shared, d) If you provide information that informs me you are in danger of harming yourself or others, e)information necessary for case supervision or consultation, f) when required by law. Email, cell phone, faxes, and social networking sites are not considered confidential.

EMERGENCY AND PHONE PROCEDURES: I am often not immediately available by telephone but I do check my messages regularly and will respond to your call within 24 hours. If an emergency arises, indicate it clearly in your message. If you are unable to reach me and feel you cannot wait for me to return your call, call 911 or go to the nearest hospital emergency room. Please do not use email, faxes, or social networking for emergencies as I do not always check them daily.

PRACTICE LIMITATIONS: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings such as , but not limited to, divorce and custody disputes, injuries, lawsuits, etc., neither you nor your attorney's nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding or to provide custody evaluation recommendations. Furthermore, I do not provide legal advice or prescribe medication as these activities are out of my scope of practice.

I have read and understand the above document and I agree to comply with it. I have received a copy of the above document as well as the HIPPA form and I agree to allow this office to submit claims to my insurance company on my behalf. I understand that I am responsible for all charges whether or not they are covered by insurance. I hereby authorize this provider to release all information necessary to secure the payment of benefits.

I understand that , because insurance cannot be billed for missed session, I will be charged $50 for any missed appointment without notice of 24 hours. I further agree that a photocopy of this agreement shall be valid as the original.

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Client Name (Print) Date Signature

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Parent (Print) Date Signature

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Counselor (Print) Date Signature