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Center for Attachment & Trauma Services, Inc.

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INFORMED CONSENT TO TREATMENT

I have been advised that the psychotherapeutic treatment (individual, family, couples, or group) provided by the Center for Attachment & Trauma Services, Inc. (CATS) is governed by the regulations of the Virginia Department of Health Professions and by the applicable ethical rules and federal, state, and local legal standards and regulations.

CONFIDENTIALITY

I understand that the information I provide to my treatment provider is held in confidence, but that there are certain limitations on this confidence. These include: a) the professional necessity to consult with colleagues or supervisors about cases, which will be done without sharing my full name or other identifying information whenever it is possible; b) providing insurance companies with information needed to process claims for reimbursement; c) informing proper authorities concerning reports of child abuse and/or neglect; d) informing proper authorities or others of imminent danger to self or others; e) other situations as required by law (i.e., when giving legal testimony). In all cases, I understand that only the minimum information necessary to accomplish the intended task with be shared. I understand that my (or my child's) confidential information may be shared with other interested parties in the event I sign a *Consent for Release and Exchange of Personal Information* authorizing this. **I acknowledge that I have read the Notice of Privacy Practices for the Center for Attachment & Trauma Services, Inc.**

CONTACT WITH THERAPISTS

I understand that calls, texts, and emails will be returned at the therapist's earliest convenience. I understand that if I have a mental health emergency, I should call 9-1-1 or go to the local emergency room. I understand that if my therapist provides a personal/business cell phone number, this number is to be used for administrative purposes only, mainly cancelling or rescheduling appointments, and that if I need to contact my (or my child's) therapist, I am encouraged to use the office email address I have been provided by my therapist.

BUSINESS HOURS OF OPERATION AND CANCELLATION POLICY

The normal business hours for CATS is 9AM to 7PM, Monday through Thursday, with limited business hours on Friday and Saturday. Appointments outside regular business hours are made at the discretion of the individual therapist. I understand that I am expected to attend scheduled appointments and that if I provide less than 24 hours advance notice of cancellation, I will be charged a late-notice cancellation fee of $65. I agree to provide a credit card number which will be kept on file with the CATS Administrative Assistant who has my permission to charge this fee in the event of a missed appointment or a late cancellation.

PAYMENT FOR SERVICES

I understand payment for services rendered by CATS is due on the day of my appointment (unless individual arrangements have been made in advance and approved by the Executive Director). I understand it is my responsibility to seek reimbursement from my insurance provider and CATS cannot guarantee eligibility for reimbursement for services provided.

RISKS AND BENEFITS OF TREATMENT

I have been advised that there is no guarantee that psychotherapy will be effective in my (or my child's) case. I understand that this treatment may be very demanding and that I may experience increased distress from time to time in the process of psychotherapy. I understand the degree of honesty and effort I put forth while receiving psychotherapy will likely correlate with a great chance of positive results. I understand that psychotherapy is based on a cooperative and collaborative effort by me (or my child and/or family) and my treatment provider(s), and for it to be most effective, I will need to be open about my (or my child's) needs and concerns. With full understanding of the above, I give full and complete consent to undergo psychotherapeutic treatment.

Authorized Signature	Name of Client	Date
Clinician's Signature	Credentials	Date