

**Teresa Fitzgerald, MA LMFT**  
1010 Jorie Blvd. Ste. 112 Oak Brook, IL 60523  
Phone: 708-341-2486  
[teresafitz@sbcglobal.net](mailto:teresafitz@sbcglobal.net)

## **OFFICE POLICY AND INFORMED CONSENT**

If possible, you may wish to print out this form and bring it with you on your first visit.

### **APPOINTMENTS**

Appointments will be scheduled at a time mutually acceptable to both you, the client, and me, your therapist. Your therapist requires 24-hour advanced notice of cancellations except in an extreme emergency. Should you miss your appointment without cancelling 24 hours in advance, you will be charged the full fee for your session. Should you need to cancel an appointment, please call me at 708-341-2486. Should you be late for an appointment, you will have the time remaining for your session. If I am late for your appointment, I will make up the time so that you receive a full 50-minute session.

### **FEES AND FINANCIAL POLICY**

Session fees will be determined at our first meeting and are based on a 50-minute session. Payment of fees for office services is required at the beginning of each session.

Clients who plan to file services rendered with their insurance company must clearly understand that payment of the full fee amount is the responsibility of the client, not the insurance company. Filing with your insurance company is no guarantee that your company will pay for services rendered through your therapist. In the event that your insurance company does not pay for services rendered, the client is responsible for payment of the full amount charged.

Should there be insufficient funds for your issued check, you will be responsible for any bank charges to the therapist in addition to the amount of the check. Should your account be delinquent, you will not be allowed to schedule future appointments until your bill is paid in full.

### **CONFIDENTIALITY**

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information to others about our work together with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There may be some special situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

(Continued)

Note that these special situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During such a consultation, I make every effort to avoid revealing the identity of my patient. I am also legally bound to keep the information confidential. If you don't object, I will not discuss these consultations with you unless I feel that it is important to our work together.

In general, the number of visits you require will depend on the type of problems that exist, the recommendations made by me, and the effort you put into working on these problems in following through with the recommendations.

**INFORMED CONSENT**

Your specific consent to the evaluation and treatment process with me, Teresa Fitzgerald, MA LMFT, is required below, and includes the understanding that this process may, in addition to you, include your child, and/or other family members. Your consent also confirms that you have the right to withdraw from counseling at any time.

*Your signature below indicates that you have read the information in this two-page document and understand the requirements and policies of my office, and agree to its terms during our professional relationship.*

Signature\_\_\_\_\_

If client is under the age of 18, note that your signature above signifies:  Parent  Legal Guardian

Date\_\_\_\_\_