

Tasnim Sulaiman, MEd., LPC
Individuals/Couples/Families/ & Sex Therapy
63 W. Lancaster Ave. Suite 11, Ardmore, PA 19003
Phone Number (267) 736-3030

Therapeutic Agreement/ Consent to Treatment

I, _____, give my permission and consent to receive psychotherapy from Tasnim Sulaiman, M.Ed., LPC.

While I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed. I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing. Working through issues can bring up difficult feelings which will be addressed in the therapy.

I understand this therapist is **not** providing an emergency service, and I have been informed to call 911 or go to the nearest Hospital Emergency Room or call Crisis Intervention if I am in a crisis/emergency situation.

I understand regular attendance, fully participating in therapy and following through on recommendations will produce the maximum benefits.

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

I understand that if I do not give **at least 24 hours notice** to cancel a session, I will be charged for the session. This fee is not reimbursable by insurance.

Sessions are 50-60 minutes long.

I agree to pay \$ _____ for the initial session and \$ _____ for each session thereafter. Payment is due at time of service.

Confidentiality

I understand that every attempt will be made by the therapist to keep conversations that occur in therapy sessions confidential. I further understand that the therapist, by law, must report certain situations. These include:

- A) Actual or suspected child, spouse, or elder abuse
- B) If I threaten to harm or injure another person (including myself). The therapist is required by law to protect the potential victim, which may include contacting that person

I understand that my information may be revealed if records are court ordered.

I understand that information may be disclosed to the insurance company for the purpose of reimbursement.

Additionally, I understand that my therapist receives supervision and might discuss some aspects of my case with her supervisor. I give my permission for her to do this.

I know of no reasons I/he/she/we should not undertake this therapy and I/he/she/we agree to participate fully and voluntarily.

Client(s) Signature: _____
(of patient or a person authorized to consent for patient)

Date: _____

_____ Date: _____

Therapist's Signature: _____

Date: _____

IMPORTANT INFORMATION REGARDING ISSUES OF CONFIDENTIALITY AND THE USE OF EMAIL, INTERNET, FAX, AND CELL PHONE AS A FORM OF COMMUNICATION

I, _____ understand that communicating with my therapist through email, website, fax and/or cellular phone contact is NOT a confidential means of communication. Communicating through these methods has several risks.

Which include, but not limited to, the following:

- The information could fail to be received and that confidentiality could be breached.
- The information could fail to be received if it is sent to the wrong email address or if it just is not noticed by the recipient.
- Confidentiality could be breached in transit by hackers or internet service providers and at either end by others who had access to the account or the computer.
- Encryption technology could fail.
- Though this practice does our utmost to protect privacy and password protect/ de-identify personal health information, human error could still occur.

By signing below, I am stating that I understand that email, internet contact, and cell phone methods are not confidential and I have been informed of the issues of confidentiality with email. Additionally, by signing below I am agreeing to release my rights to confidentiality when I communicate with my therapist these methods.

Client's Signature Date

Therapist's Signature Date

In addition, I prefer to communicate through (PLEASE INITIAL ALL THAT APPLY):

___ land line telephone: _____

___ cell phone: _____

___ email: _____