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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/PSYCHOLOGIST RELATIONSHIP: You and Dr. Cook 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. Dr. Cook 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 trade of service for service.

AVAILABLE SERVICES: Dr. Beth Cook offers a wide array of therapy services, including individual, family, couples, and group services. Effective psychotherapy is founded on mutual understanding and good rapport between client and Psychologist. It is my intent to convey the policies and procedures used in our practice, and I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Psychotherapy may be beneficial, but as with any treatment, there are inherent risks. During therapy, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of treatment can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. Dr. Cook cannot guarantee these benefits, of course. It is her desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

TREATMENT: Dr. Cook provides short-term treatment designed to address many of the issues clients are dealing with. Your first visit will be an assessment session in which you and Dr. Cook will determine your concerns, and if both agree that there is a good therapeutic fit, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you, services to you may be terminated.

The goal of psychotherapy is to provide the most effective therapeutic experience available to you. If at any time you feel that you and Dr. Cook are not a good fit, please discuss this matter as soon as possible. If either party decides that other services would be more appropriate, Dr. Cook will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Psychotherapy services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 60 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by Dr. Cook. If you must cancel or reschedule your appointment, please give Dr. Cook at least 24 hours advance notice of a cancellation, whenever possible. This will free your appointment time for another client. Full session fee may be charged at the discretion of Dr. Cook for appointments canceled without 24 hours notice.

FEE SCHEDULE:

Diagnostic & Evaluation Session (1st visit)	$250
Regular Office Visits (60 minutes) (Individuals, Couples Therapy)	$190
$25 Returned check fee per check	
A reasonable fee will be charged for copies of any records requested by the Client.	

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. Dr. Cook requests that payment be made at the end of each session. If you are using insurance benefits, Dr. Cook will file insurance claims for you.

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact Dr. Cook 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, we will make every effort to respond to your emergency in a timely manner. If your emergency arises after hours, you may try to reach Dr. Cook but if it is a serious crisis, and if you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

CONFIDENTIALITY: Dr. Beth Cook follows all ethical standards prescribed by state and federal law. She is 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 Psychologist 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; suits in which the mental health of a party is in issue; situations where the Psychologist has a duty to disclose, or where, in the Psychologist's judgment, it is necessary to warn or disclose; fee disputes between the Psychologist and the client; a negligence suit brought by the client against the Psychologist; 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 Psychologist when you and the Psychologist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Psychologist 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 Psychologist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If Dr. Beth Cook believes that I am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to Dr. Cook to contact the 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 her to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate.

Name	Telephone Number
_____	_____
_____	_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Psychologist, it will be necessary to assign my case to another Psychologist and for that Psychologist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Psychologist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

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 appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or the Conserved Individual if said individual is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a Conserved Individual, if a court order has been entered with respect to the conservatorship of said Conserved Individual, or impacting your rights with respect to consent to the Conserved Individual's mental health care and treatment, Dr. Beth Cook will not render services to the Conserved Individual until the Psychologist has received and reviewed a copy of the most recent applicable court order.

_____	_____
Signature – Client/Guardian	Date
_____	_____
Signature – Spouse/Partner/Guardian	Date
_____	_____
Psychologist, Dr. Beth Cook	Date

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

_____ _____

Client/Guardian Date

I authorize the payment of medical benefits to the provider of services.

_____ _____

Client/Guardian Date