DIANA
FINLAYSON
LCSW

DIANAFINLAYSONLCSW.COM | 615.294.9740
DIANA@DIANAFINLAYSONLCSW.COM

Date

Last Name First Name

Street Address City, State Zip

Age Sex Marital Status

Referral Source

Phone Number E-mail address

May I contact you at the above phone number? Yes/ No

May I contact you at the above e-mail address? Yes/ No

Emergency Contact/Relationship Phone Number for Emergency Contact

Occupation Employer

Why have you decided to seek therapy at this time?

Have you had previous experience with psychotherapy? Yes/ No

Was this experience helpful? Yes/ No

Please list any medical problems or medications you are currently taking:

INFORMED CONSENT FOR TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies.

THERAPY

Psychotherapy is a collaborative process between the therapist and client. We will work together as we explore your history and identify goals for the future.

APPOINTMENTS

Appointments are 50 minutes in duration. If you need to cancel or reschedule a session, please provide 24 hours notice. If you miss a session without canceling, or cancel with fewer than 24 hours notice, my policy is to collect the full fee for the session. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

FEES

The fee per 50 minute session is $120 and payment is due at the time of the session. I do have a limited number of sliding scale spots available. To qualify for a sliding scale fee, your household income must be under $75,000/ year. Please let me know if you would like to discuss a sliding scale fee.

INSURANCE

I do not contract with insurance companies for payment. However, your insurance company may provide "out of network" behavioral health benefits. Please check with your insurance company to determine if they will reimburse you for my services as an out of network provider. If so, they will likely reimburse you for a portion of the fee that you paid me. You will be responsible for submitting all necessary paperwork in order to receive reimbursement from your insurance company.

If you would like to seek reimbursement from your insurance company, I can provide you with a receipt detailing the services that have been provided. Please note that this involves my supplying the insurance company with a diagnostic code from the DSM-V (Diagnostic and Statistical Manual of Mental Disorders). If you have concerns about this information becoming a part of your health record, please discuss with me.

CONFIDENTIALITY

The information you provide to me during your therapy is legally confidential with some exceptions. Legal exceptions to confidentiality include:

1. When I believe you are in danger of harming yourself or another person or you are unable to care for yourself.

2. Suspected abuse or neglect of a child, elderly person or a disabled person

3. If I am ordered by a court to release information as part of a legal involvement.

You may give me permission to release information to others with your written consent.

By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction.

Signature Date