Breena Freid, LCSW
5225 Old Orchard Rd. Suite 6
Skokie, IL. 60077

AGREEMENT SERVICE/INFORMED CONSENT

Introduction
The following information describes the operation procedures of Breena Freid's practice. Please read it carefully. If you have any questions, I will be happy to answer them. Please keep a copy of this form for future reference.

I. The Therapy Process
Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Change will sometimes be easy and swift, but more often it will be slow and frustrating. Remembering unpleasant events and resolving them though therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and my result in changes that were not originally intended. When working with children, behavioral symptoms often increase before positive changes occur.

II. Client's Rights
You have the right to a confidential relationship. Within certain legal limits (see #3 below), information revealed by you during the course of therapy will be kept completely and will not be revealed to any person without your written permission.

1. You have the right to know the content of your records at any time and I have the right provide you with the complete records or a summary of their content. This must be done in writing.
2. If you ask me, I can release any part of your records on file to any person you specify. This must be done in writing. I will tell you when you make your request whether or not realizing that information to that agency or person might be harmful to you at any time.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:

a) If you reveal information about active child abuse or neglect, elder abuse, or dependent physical abuse. I must make a report to protective services. When a perpetrator of child abuse is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors, I must also report that information.

b) If you seriously threaten harm or death to another person, I am required to warm the intended victim and notify the appropriate law enforcement agencies

c) Suspected elder abuse or neglect. If information related to abuse/neglect of a person 65 or over is obtained during the course of treatment, this information will be immediately released to appropriate authorities.

d) Suicidal intent. I may disclose information to others regarding the client's mental status if suicide or self harm is determined to be a risk.

e) If you are in therapy due to an order of a court or lawyer, the result of the treatment ordered must be revealed to that court or lawyer.

f) If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.

4. Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personal identifying information regarding you or your family members caregivers.
5. You have the right to ask questions about any of the techniques used in the course of your therapy. I will explain my customary approach and method to you.
6. You have the right to choose NOT to receive therapy from me. If you choose this, I will provide you with names of other qualified professionals whose services you might prefer.
7. You have the right to terminate therapy without any financial, legal or moral obligations other than those you've already incurred.
8. I have the right to terminate therapy with you under the following conditions:
   a) When I believe that therapy is no longer beneficial to you.
   b) When I believe that you will be better served by another professional, whom I will recommend. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent from you, I will provide that professional with the essential information that he or she requires.
   c) When you have not paid for the last two sessions, unless special arrangements have been made.
   d) When you have failed to show up for your last two therapy sessions with a 24 hour notice.

III. Fees

The usual and customary fee for service is $___150 per 50-minute session, due at the end of each session. Longer than 50 minute sessions are charged for the additional time pro rata. I reserve the right to periodically adjust this fee. You will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, HMOs, managed care organizations, or other third-party payors, or by agreement with Therapist. The agreed upon fee between Breena Freid, LCSW and Representative is $_______. You are responsible for any covered or non -covered services defined by your insurance. From time to time, I may engage in telephone contact with you other than scheduling sessions. You are responsible for pay of the agreed upon fee for any telephone calls longer than ten minutes. In addition, from time to time, I may engage with third parties at the request of you and with the advance written authorization

from you. You are responsible for payment of the agreed upon fee (on a pro rated basis) for any telephone calls longer than ten minutes.

IV. Insurance

You are responsible for any and all fees not reimbursed by his/her insurance company, managed care organization, or any other third-party payor. You are responsible for verifying and understanding the limits of his/her coverage, as well as his/her co-payments and deductibles.

You authorize the use and disclosure of your personal health information for the purposes of diagnosing or providing treatment to you or another family member obtaining payment of care, or the purpose of conducting the healthcare operations of the practice. You authorize Mrs. Breena Freid, LCSW to release information required in the process of applications for financial coverage fore the services rendered. This authorization provides that Mrs. Breena Freid, LCSW may release clinical information related to your or any other family member's, diagnosis and treatment, which may be requested by my insurance company or its designated agent.

I will submit a written statement for billing to your insurance company at the end of each month.

V. Cancellation Policy

You are responsible for payment of the agreed upon fee for any missed session(s). You are also responsible for payment of the agreed upon fee for any session(s) for which you fail to give at least 24 hours notice of cancellation. Cancellation notice should be left on my voicemail at (847)-757-7711.

VI. Therapist Availability

I will make every effort to return you calls within 24 hours (or by the next business day), but cannot guarantee the calls will be returned immediately. I am unable to provide 24-hour crisis serviced. In the event the client is feeling unsafe or requires immediate medical or psychiatric assistance call 911 or go the nearest emergency room.

VII. Patient Litigation

I will not voluntarily participate in any litigation, or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with client's attorney and will generally not write or sign letters, reports, declarations or affidavits to be sued in any legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate of $150 hr. I will not make any recommendations as to custody or visitation regarding the client. I will make efforts to be uninvolved in any custody dispute between the client's parents.

Adult Consent for Treatment

I _______________________________________hereby consent to the treatment provided by Mrs. Breena Freid, LCSW. I authorize the mental health care services deemed necessary or advisable by Mrs. Breena Freid to address my needs.

I have read and fully understand this Consent for Treatment Form.

Date_________________ Client's Signature____________________

Date__________________ Therapist's Signature_______________________

Consent for Couples or Family Therapy

As a couple/family we agree to engage in therapy which will include both joint and individual sessions. I understand my right to confidentiality in individual sessions, am willing to waive that right so that information shared in individual sessions can be shared in joint session at the discretion of the therapist.

I also understand that my therapist believes that couple/family therapy is most successful when a family is willing to be completely honest with the therapist and with each other. For this reason, Breena Freid has explained that she is unwilling to collude with secrets. Where a family member shares information with Breena Freid it will be discussed in joint sessions to maintain an atmosphere of openness and honesty.

I hereby consent to the treatment provided by Mrs. Breena Freid, LCSW. I authorize the mental health care services deemed necessary or advisable by Mrs. Breena Freid, LCSW to address my needs.

I have read and fully understand this Consent for Treatment Form.

Date___________________ Family Member Signature____________________________

Date____________________Family Member Signature___________________________

Date ___________________Family Member Signature___________________________

Date___________________Family Member Signature___________________________

Date____________________Family Member Signature___________________________

Date____________________Family Member Signature____________________________

Date_____________________Therapist's Signature________________________________