Informed Consent and Payment Agreement

☐I hereby agree to undergo psychotherapy on a voluntary basis with Diane McCormack, Ph.D. I clearly understand that her role is to facilitate an emotionally safe atmosphere in which I feel free to share my concerns and learn more about myself. I understand that this role is to listen to me, advise me, and at times make interpretations about my behavior.

☐I understand that my identity and disclosure in therapy are strictly confidential unless I discuss plans concerning suicide or homicide, or if I discuss child abuse or elder abuse. I understand that if I am using insurance, my insurance carrier will receive information when I submit for reimbursement and may audit my chart.

☐If, at any time, I am uncomfortable with the treatment I am receiving, I agree to discuss this with Dr. McCormack. I understand that I am free to terminate treatment at any time; however, I agree to discuss this with her at least 2 sessions before my final session in order to have therapeutic closure.

☐I am aware that therapy may be emotionally painful and a normal part of the process of self-understanding and awareness which can lead to an improved quality of life. I understand that any decisions I make are of my own volition and that there are no guarantees being offered.

☐I understand that Dr. McCormack's initial consultation fee is $175 for 45-50 minutes, and her fee for following sessions is $120 for 45-50 minutes. Sessions for couples are $250 for 90 minutes and legal work is $250 per hour including travel time. I agree to pay for my therapy sessions at the time of the appointment. If during my treatment my financial situation changes, I will discuss this with Dr. McCormack and we can arrange an alternative payment schedule.

☐Dr. McCormack will provide me with a receipt which I can submit to my insurance company, if I so choose, for reimbursement. I understand that insurance will not reimburse me for missed sessions, late cancellations, phone sessions, letters, reports, or legal involvement and I agree to pay these expenses out of pocket. Furthermore, due to the nature of insurance and the many policy changes that occur, I understand that I am responsible for knowing my insurance coverage, deductibles, and if Dr. McCormack is considered an approved provider. Failure to comply with this suggestion could result in my being responsible for all costs incurred. (Please remember that your insurance policy is between you and your insurance company and not with the insurance company and your therapist.)

☐I agree to cancel all appointments with a minimum of 24 hours advance notice or to pay for my missed session. This courtesy makes it possible for another client to have use of the time and for Dr. McCormack to meet her financial obligations.

☐In case of an emergency, I understand that I can call **Wayne County Crisis Center** at **(313) 224-7000**, **Macomb County Crisis Center** at **(810) 307-9100** or the **Oakland County Crisis Center** at **(248) 456-0909**. Or I may go to the emergency center of the nearest hospital.

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Signature	Social Security Number	Date