***Jessica Purtan Harrell, Ph.D.***
*Licensed Psychologist*
*248-767-5985*

## Consent to Treatment

I do seek and consent to take part in the treatment provided by Jessica Purtan Harrell, Ph.D. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest and will be completed collaboratively with her guidance and my input. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will be responsible for is paying for the services I have already received.

I am aware that Dr. Harrell maintains a **fee for service practice**. This means that I must pay for services out of pocket and that I am responsible for all payments. If Dr. Harrell provides me with information to facilitate reimbursement by third party payers, I understand that she will need to release some protected health information to facilitate this. I understand that Dr. Harrell does not submit bills to insurance companies; if I want reimbursement, I will be responsible for seeking my own reimbursement.

I know that I must call to cancel an appointment at leas **24 hours** before the time of the appointment. If I do not cancel at least 24 hours in advanced and do not show up, I will be charged for that appointment. I agree to pay for missed appointments or those where I fail to give enough notice that I will not attend. I am aware that Dr. Harrell does not accept insurance and that it will be my responsibility to seek reimbursement from my insurer if I so desire.

During the process of treatment, I understand that at times I may feel an increase of distress. I will discuss this with Dr. Harrell so that she may facilitate my growth. I understand that my sessions will be kept confidential. Exceptions to confidentiality include should I be at risk to harm myself or another person and in cases of suspected child or elder abuse or neglect. I agree to disclose thoughts of hurting myself or others to Dr. Harrell and to work with her to develop and implement a plan for my safety. Dr. Harrell is legally and ethically obligated to breach confidentiality if I am at serious risk or harming myself or another person.

My signature below shows that I understand and agree with all these statements.

Signature: _____

Printed Name: _____

Date: _____