Samantha Fox, LMFT 352 7th Avenue #1604 New York, N.Y. 10001
917.830.6828

Informed Consent for Treatment

I _____, agree to receive psychotherapy services from Samantha Fox, LMFT on a 45-minute per individual session basis or 60-minute per couple session basis for a period of time to be determined by mutual agreement.

I understand that payment of $_____(In the form of check, venmo or cash) is due at the beginning of each session, unless other arrangements are made, and a prorated fee will be charged for sessions having to run overtime. Checks should be made out to Samantha Fox, LMFT. I understand that I am responsible to pay a $30 fee if a check I write is returned.

I understand that my provider may change the fee per session in the future and that I will be given one months notice before the fees increase. For sliding scale treatment, the fee will be revisited after a set number of sessions and will continue to be reassessed based on need.

I understand that maximum benefit will occur with consistent attendance and I agree to keep regular appointments. If I need to cancel or change an appointment I will give as much notice as possible, and I agree to pay for a missed appointment if I have not given at least 48 hours notice. If I need to reschedule an appointment due to vacation, work or family commitment, I will notify Samantha Fox as soon as possible, preferably at least one week prior to the time of my appointment.

I understand that I am receiving treatment in a private practice setting without 24-hour availability. If I feel I need more support than once a week sessions I agree to discuss this with Samantha Fox and work together to create a plan with additional services for more support. If I have an emergency, I understand that I need to call 911. I also understand the following support is available to me if needed:

NYC Safe Horizons numbers:
Domestic Violence Hotline: (800)- 621-HOPE (4672)
Crime Victims Hotline: (866)-689-HELP (4357)
Rape, Sexual Assault & Incest Hotline: (212)-227-3000
National Suicide Hotlines: (800)- SUICIDE (784-2433)
(800)- 273-TALK
Suicide Prevention Hotline: The Samaritans of NY: (212)- 673- 3000

I understand that I am free to terminate treatment at any time but that advance notice and a termination process running the course of several sessions is most beneficial to me.

Confidentiality Notice

I understand, that within certain limits, information revealed by me during treatment will be kept strictly confidential and will not be revealed to any other person or agency without my written permission.

I understand that there are several situations in which my provider is required by law to reveal information obtained during treatment to other persons or agencies WITHOUT MY PERSMISSION.

- If I threaten bodily harm or death to another person, my provider is required by law to inform appropriate agencies.
- If I threaten bodily harm or death to myself, my provider will inform law enforcement agencies and others (such as my spouse/ partner, emergency contact person, or an inpatient psychiatric institution) who could aid in prohibiting me from carrying out my threats.
- If a court of law issues a legitimate subpoena, my provider is required by law to provide the information described in the subpoena.
- If I reveal information relative to child abuse and/or neglect, or elder abuse my provider is required by law to report this to the appropriate authorities.
- If I am in treatment, or being assessed by order of a court of law, the results of the treatment or evaluation ordered must be revealed to the court.

Other Considerations

I understand that my provider is not a psychiatrist and cannot prescribe medication or give recommendations about medication. I also understand that, depending on the nature of my presenting concerns, my provider might require me to consult with a psychiatrist before proceeding with treatment.

I understand that my provider may feel that my reason for seeking treatment is beyond the scope of her practice. My provider works collaboratively with other mental health professionals and may refer me to another therapist.

I understand that the process of psychotherapy can bring up difficult emotions that may cause me to feel like things are becoming more

difficult before I begin to feel better. I understand that this is part of the process and a part of my treatment.

Consents and Agreements

As a client of Samantha Fox, LMFT, I consent to be the recipient of treatment. I have received a copy of 'Informed Consent for Treatment', including the 'Confidentiality Notice'.

Client Signature:_____Date:_____
Print Name_____Age: _____
Male/Female/Trans/Gender fluid (circle one)
DOB:_____
Street Address_____Apt#_____
City _____State_____Zip_____
Personal Phone # _____Msg OK?_____
Work#_____Msg OK?_____

Partners Information (**For Couples/Families Only**)
Client Signature:_____Date:_____
Print Name_____Age: _____
Male/Female/Trans/Gender fluid (circle one)
DOB:_____
Street Address_____Apt#_____
City _____State_____Zip_____
Personal Phone # _____Msg OK?_____
Work#_____Msg OK?_____

Emergency Contact Information (REQUIRED FOR TREATMENT)
*Please note that your emergency contact may be contacted in the event of an emergency

Name_____Relationship_____
Phone Numbers_____
Full
Address:_____

Provider Signature:

_____Date_____
Samantha Fox, LMFT