# Robyn P. Waxman, Ph. D

660 Kenilworth Drive, Suite 101, Towson, Maryland 21204 Phone: 410-933-1465 Fax: 877-561-9741
www.robynwaxmanphd.com

## Child/Adolescent Consent for Treatment

The decision to begin psychotherapy is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. I have developed this consent form to provide you with an overview, but please feel free to ask any questions that you have regarding any of the information included here, or about the therapeutic process in general.

## Confidentiality of Mental Health Information

I place the highest value on the confidentiality of your records. Records will be held confidential except as required by law or as released by your written authorization. In a small number of situations, I am legally required to reveal information: for example, if you reveal information that indicates a clear danger of injury to yourself or others, suspicion of child abuse or by court order. Also, under certain insurance contracts, your records may be reviewed for quality and appropriateness of care by your insurance company or an external gatekeeper. If I am on vacation, I will always have another qualified psychologist covering for me in the case of a patient emergency. Please understand that in the event of an emergency, during my absence, information may be discussed between myself and the professional who is covering for me in order to maintain continuity of care and quality of service.

## Payment of Fees

Payment for your therapy is expected before each session. Payment may be in cash, check or by credit card. I do not currently participate in any insurance panels. You will be expected to pay for each session in full. I do provide billing services and we will be happy to submit all claims on your behalf when your policy permits this. Some HMO policies do not allow for balance billing by an Out-of-Network provider. If your policy does not allow for balance billing, you may be forfeiting your right to submit invoices for reimbursement**. It is important that you recognize that you are entering a private contract with a non-participating provider and that unless your HMO explicitly allows for balance billing, you will not be able to use your insurance.** In those cases, we can not submit your claim; however, you will receive a written statement. Please read your plan's booklet for coverage to determine the deductibles and your Out-of-Network benefits (I will be considered an Out-of-Network provider). You are responsible for seeing that my services are paid for promptly. Meeting this responsibility demonstrates your commitment to our professional relationship.

If you ever become involved in a legal dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should have a different psychologist who specializes in forensic psychology for any evaluation or testimony you require. Further, any legal reports, depositions, or appearances or conversations associated with our treatment will be your sole responsibility for payment of a fee of $450.00/hour with any portion of an hour to be charged at the hourly rate.

## Appointments and Cancellations

Individual sessions usually last 50 minutes. Your first session will typically be devoted to (1) assessing the extent of your concerns, (2) determining treatment goals, and (3) planning your treatment. I cannot promise that I will be available at all times as I do not take calls while I am in session. You can always leave a confidential message on my voicemail and I will return your call as soon as I can.

Generally, I return messages daily, except on weekends and holidays. If you have an emergency or crisis that requires immediate attention, you or your family should call one of the following emergency agencies: Baltimore Crisis Response at (410) 752-2272 or your local community hospital emergency room.

Your sessions will be scheduled at a time that is mutually agreed upon. If either you or I are unable to keep an appointment, every effort should be made to contact the other party well in advance. Our schedules are both very busy. The cancellation of an appointment without sufficient notice means the loss of a therapy hour that could have been scheduled for somebody else. **Therefore, the policy is that appointments that are not cancelled by you at least 24 hours in advance will be charged to you at the usual rate, except in the event of an unavoidable emergency**. Cancelled appointments are not covered by insurance.

## Rights and Responsibilities

Dr. Waxman is licensed to practice psychology by the Maryland State Board of Examiners of Psychologists and adheres to the Ethics Code of the American Psychological Association.

I, _____, have read the above, and understand and agree to my responsibilities. I understand that I can choose to discuss my concerns with Dr. Waxman before I start formal therapy. I understand that Dr. Waxman is in independent practice and is in no way connected to the other independent providers in her suite. I understand that I am financially responsible for charges whether paid by insurance or not. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I hereby authorize Dr. Waxman to release information necessary, concerning diagnosis and treatment in order to secure payment of incurring charges. I understand that it is my responsibility to inform Dr. Waxman if the minor's parents are separated or divorced. **In cases of separation and/or divorce, both parents must consent to treatment.** I hereby give consent for my child/adolescent to enter into therapy with Robyn P. Waxman, Ph.D. and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____

Signature of Parent Date

_____ _____

Robyn P. Waxman, Ph.D. Date
Maryland Licensed Psychologist, #3469

# Robyn P. Waxman, Ph. D

660 Kenilworth Drive, Suite 101, Towson, Maryland 21204 Phone: 410-933-1465 Fax: 877-561-9741
www.robynwaxmanphd.com

## Authorization for Release of Information

I hereby give my informed consent to Robyn P. Waxman, Ph.D. to exchange information with:

Name: _____

Phone: _____

Fax: _____

Address: _____

_____

regarding assessment and treatment for _____.
*Client Name*

This consent will automatically expire one year from the date signed by the client or legal representative and may be revoked by the undersigned at any time.

---

_____
Name of Client (please print)

_____ _____
Signature of Client or Client's Legal Guardian Date

_____ _____
Robyn P. Waxman, Ph.D. Date
Maryland Licensed Psychologist, #3469