LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

CANCELLATION & PAYMENT POLICY

If you fail to cancel a scheduled appointment, I cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice. In this event, the below credit card will be charged to cover the cost of the missed appointment or late cancellation fee. A receipt will then be mailed directly to you. This credit card information will be held securely along with the contents of your treatment file.

If you choose to terminate therapy and have an outstanding balance on your account, you are authorizing your credit card to be charged for the amount of your outstanding balance. You will then be sent an invoice indicating that the amount has been paid in full.

Credit Card Information

Card Number _____

Expiration Date _____

CCV _____

Zipcode for CC Billing Address _____

Authorized Signature indicating your agreement to bill the above credit card for any missed appointments, late cancellation fees, and any remaining outstanding balance at the time of therapy termination.

_____

Signature of Cardholder

I have read and understand the above terms and conditions of Dr. Helmholdt's Cancellation Policy and Billing Procedures.

_____ Client Signature (Client's Parent/Guardian if under 18)

Thank you for your consideration regarding this important matter.