

*Crane Counseling, LLC*  
*7313 Millwood Road*  
*Bethesda, MD 20817*  
Office: 301.370.9794 www.Cranecounselingllc.com  
EIN: 45-2263500/NPI: 1902293087

## **INFORMED CONSENT FOR PSYCHOTHERAPY**

I/we have been given and have read the material provided by Crane Counseling, LLC regarding their psychotherapy practice on its website, www.cranecounselingllc.com.

I/we have read and understand the background, philosophy and approach that Crane Counseling, LLC has disclosed in their statement.

### **OFFICE POLICY**

I/we also understand and accept the terms as outlined in the material provided regarding confidentiality, office policies and procedures, e-mail communication, fees, and client rights and responsibilities. **I/We have agreed to the fees for services, as indicated in the terms.** If not, we have agreed to the following fees for services:  
\_\_\_\_\_ to be re-evaluated in 3 months.

I/we understand the fees as outlined with this practice. I/we understand that Crane Counseling, LLC does not take insurance of any kind and therefore I/we are responsible for the payment at time of service. However, these services may be covered under my/our medical savings plan. Extended appointments, phone consults and administrative issues related to insurance issues or safety plans will be charged an extra \$1/minute.

**I/we also understand that I/we must cancel appointments 48 HOURS IN ADVANCE by phone in order to avoid a charge of the regular session fee** unless there are extenuating circumstances, as outlined in the material provided – or agreed upon separately and in writing between individual client/s and therapist. I/we understand that if I/we want to reschedule for the same week and Crane Counseling, LLC has availability, I/we can switch the appointment date/time without additional fees. I/we understand that if there is a pattern of 'no show' appointments, it may result in an additional fee or termination of services.

### **TELETERAPY OR IN PERSON THERAPY POLICY**

**(See separate \*Teletherapy Informed Consent)**

I/we understand teletherapy or in-person sessions are both options for treatment. I/we understand that we will agree in advance about which treatment medium will be employed whenever possible (Examples illness, medical emergency or weather-related safety concerns).

I/we give permission for Crane Counseling, LLC to contact me by (please initial) \_\_\_home \_\_\_work \_\_\_cell. I/we also consent to TEXT messaging to change/confirm appointments, if necessary, by either client or therapist.

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## **HIPAA POLICY**

### **HIPPA POLICY CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as “health care operations.”). Nevertheless, we ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of my Notice at any time. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

I/we understand the I/we may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary; client/s may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked. I/we hereby consent to the use or disclosure of my Protected Health Information as specified above. I/we hereby acknowledge that I have received and have been given an opportunity to read a copy of Crane Counseling, LLC’s Notice of Privacy Practices. I/we understand that if I have any questions regarding the Notice or my privacy rights, I can discuss them with my Crane Counseling, LLC therapist. Further inquiries can be addressed to the Secretary of Health and Human Services, 200 Independence Avenue, SW, Washington, D.C. or by calling 202-619-0257.

**Please sign below to acknowledge that you have read, understood and agree to the terms previously described.**

\_\_\_\_\_  
SIGNATURE of Client/Parent/Guardian

\_\_\_\_\_  
SIGNATURE of Client/Parent/Guardian

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF THERAPIST,  
CRANE COUNSELING, LLC

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