Ann Woodward Hines, MA,
Licensed Marriage and Family Therapist
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INFORMED CONSENT: PRIVATE PRACTICE

I, (Over 18 or parents of minor child): _____
voluntarily consent to services provided by Ann W. Hines, Licensed Marriage and Family Therapist #MFT20813,
For myself or **my children (names below):**
_____
_____
_____
These services may include individual, couple, child and family therapy or parent consultation. I understand that psychotherapists do not guarantee particular outcomes. I am seeking these services on my own accord and am free to discontinue at any time. I understand my therapist's training, credentials, and experience as well as the nature of the therapeutic process.

I understand and agree to the following terms:

CONFIDENTIALITY will be maintained and information will be released only to qualified professionals and only with my explicit written permission, except in certain situations where maintaining confidentiality would result in clear and imminent danger to myself or others, or as otherwise provided by state law. The therapist is required by law to report to the appropriate authorities any suspected child abuse, elder abuse or abuse of people with disabilities. When a threat of bodily harm to myself or to others is present, the therapist may break the confidentiality of our communications. If I would like my therapist to consult with my own or my child's physician, prior therapist, or teacher, I will include their names and contact info on the "Release and Exchange of Information" form.
Therapeutic supervised visitation and re-unification therapy often require reports in response to judge or mediator requests for information on how the process is proceeding. Parents will need to sign a release of information for family court before we begin either of the above processes.
I understand confidentiality and its exceptions as explained in this

form.

CUSTODY: If a parent has **sole legal** custody of a minor client, the court order must be provided for the therapist. **If parents share joint legal custody, both parents must consent to treatment for their child.** The therapist meets with parents without the child present, individually or together, before child therapy sessions commence. If one parent does not live locally, he/she must initiate phone contact with the therapist, as well as sign and deliver the Informed Consent Form for their child's therapy before treatment begins.

FEES:

I understand that Ann Woodward Hines, LMFT is not contracted with insurance panels. **If you have a PPO insurance policy, please call your insurance company to inquire about what you will be reimbursed for out-of-network providers.** If you have an HMO policy, it is required that you see a clinician on their managed care list unless you choose to pay out-of-pocket.

HEALTH INSURANCE BILLING CODES & FEE SCHEDULE:

Individual: 45 min: CPT code 90834= $130

30 min: CPT code 90832= $90

60 min individual: CPT code 90837= $160

60 min couple or co-parent session: $175

75 min couple or co-parent session: $200

Zoom and phone sessions billed at above rates.

Stipulated re-unification therapy w/collaborative time fees are:

60 min: $175, 45 min: $150, 30 min: $100

Fees are due in the form of check, credit or debit card, or cash at the time of service.

Report writing, collaborative consultation and cumulative email time will be billed at the usual hourly rate or portions thereof, but are not reimbursable by insurance. I am aware that any professional time spent consulting on my case, in-depth phone calls or emails, or driving to collaborative appointments, school meetings outside of the office will be charged to my account.

CANCELLATIONS: I understand that I am responsible for the full fee for no-shows and cancellations without 24 hours notice.

I have asked any questions that I need to ask to understand this content

SIGNED: SELF/ OVER 18: _____

MOTHER/LEGAL GUARDIAN_____

FATHER/LEGAL GUARDIAN_____

DATE: _____