BROOKE M. SKLAR
PSYCHOTHERAPY

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## Informed Consent:

Welcome. This document provides important information about my practice. Please take as much time as you need to read it and sign at the bottom. I will provide you a copy to take with you.

**Limits to Confidentiality:**
All information disclosed within sessions is confidential with the following exceptions required by law. 1) when there is knowledge or reasonable suspicion of abuse of a child, elderly or disabled person, 2) where the client presents an imminent danger to his/herself or to others and 3) if records are subpoenaed by the court.

**Fee and Payment:**
My fee per 50 minute therapy session is $185. Payment is appreciated at the time of each visit.

**Insurance:**
I am an out of network provider. I will provide you with a statement (superbill) monthly that you can submit to your insurance plan. If your plan provides mental health coverage you may be reimbursed for a portion of the fee directly by your insurance company.

**Cancellation Policy:**
Therapy sessions are reserved for you and/or your child. If you or your child cannot make an appointment, please contact me to cancel or reschedule as soon as possible, giving at least 24 hours notice. If you fail to attend your appointment, or cancel less than 24 hours before your scheduled appointment time, you will be charged in-full for the missed session.

**Contacting me:**
Messages can be left on my voicemail anytime. Calls on a business day will usually be returned on the same day but not later than the next business day. Calls on the weekend or on holidays will be returned on the next business day. If I will be unavailable for an extended period of time I will provide a colleague who you may contact if needed. If you are unable to contact me and feel that it is an emergency you could contact your regular physician or visit a local emergency room.

I look forward to working with you.

______________________________ ____________________
Client/Patient (PRINT NAME) Date

______________________________ ____________________
Client/Patient Signature Date

___________________________________ ____________________
Minor Client: Parent/Guardian Signature Date