Trish Fitzgibbons Anderson, MA LMFT
Experience you can trust.

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CONSENT FOR TREATMENT

Name____

Address ____

City _____________________________________ **State** _________ **Zip** __________

Preferred Phone _________________________________ **Circle: Home Work Cell**

Email ____

Where do you prefer to be contacted? ____ phone ____ email _____either

Birth Date _________ Referring Person/Organization? ______________________

May I thank them for the referral? ___________

Fees are **$160** per hour, and all fees are payable at the time of service. ***24 hour cancellation notice is required to avoid payment for missed sessions.***

You have the right to expect complete confidentiality with the exception of mandatory reporting as follows: mental health professionals are required by law to report physical harm or sexual abuse of a minor or vulnerable adult. We are also required by law to report the threat of harm to self or to a third party.

This consent also applies to the utilization of telehealth, which is bound by the same rules of confidentiality as above. It is expected that all parties will utilize a secure internet connection for telehealth sessions, and sessions will not be recorded without permission.

Please sign below to indicate your informed consent to the above conditions of our therapeutic relationship.

Signature ____________________________________ **Date** ______________

Relationship to person above if not self ________________________________